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January 1980 • Vol. 73 • No. 1

The JOURNAL

of the **INDIANA**
STATE MEDICAL ASSOCIATION



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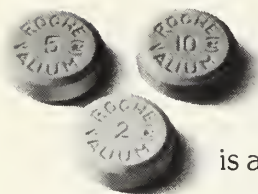
Inside: • **TRIBUTE TO GOETHE LINK, M.D.**
Goethe Link Centenary Vascular Laboratory Dedicated

• **THE INDIANA STATEWIDE MEDICAL EDUCATION SYSTEM**
The program has more than achieved its goals

• **UNDERSTANDING THE SLEEP APNEA SYNDROMES**
A Continuing Medical Education article

San Francisco, CA 94143

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

Valium®
diazepam/Roche
2-mg, 5-mg, 10-mg scored tablets
a prudent choice in psychic
tension and anxiety

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® (diazepam) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10.



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MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

Problems, Problems... Even in 1905

Life was less hectic in 1905. Most Indiana physicians were using the horse and buggy to reach places too far for walking, but a few were adventurous and took early to the automobile.

The ad shown here (from Page 5 of the *Indianapolis Star*, Nov. 13, 1905) demonstrates an industry attempt to lure more physicians into the horseless buggy era. Note that for \$1.00 per day the dealer offered to keep the automobile in "oil, gasoline and repair," among other services.

Indiana had about 1,600 automobiles in 1905, an average of fewer than 20 per county. Even so, they were enough to make their presence known, and enough to excite the state legislature into taxing and regulating activity.

Senator J. M. Singer of Versailles introduced a measure specifying that any man driving a machine should send a herald 50 yards ahead to tell people his auto was approaching. This didn't become law, but other measures did.

The speed limit for built-up sections of Indiana towns was set at 8 MPH. In the country the limit was 20 MPH. Each machine was required to have a brake and a horn. Furthermore, "an alarm shall be sounded on approaching any horse vehicle, and upon the signal of the person in the horse vehicle, the automobile driver shall stop until the horse vehicle can pass." The 1905 law also required that each machine be registered with the Secretary of State, who would provide a number to be placed on the rear of the machine.

Among the physicians still using

The Maxwell

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We will sell you our new 1906 Maxwell, price \$125 with top, and guarantee to keep it in oil, gasoline and repair, storage, wash and clean, for \$1.00 per day.

You have no repair bills, no storage bills, no worries. The 1906 Maxwell is the best light car in the world for a physician, and the maintenance is less than on any other car built.

If you wish a winter and summer car, an ideal light driving car, one your child can operate, one your wife can use, we can recommend the 1906 Maxwell. Let us hear from you. Yours Truly,

THE FISHER AUTOMOBILE CO., Exclusive State Agts. for the Maxwell

the horse at this time were the emergency room interns at City Hospital and City Dispensary in Indianapolis, whose ambulances were horsedrawn. Less well known is that, for many of their emergency runs, the interns used bicycles.

Among the more adventurous physicians using the automobile at that time was Dr. Albert E. Sterne.

One day in early June 1905, Dr. Sterne, together with his wife and chauffeur, set out from Indianapolis for West Baden via Columbus. When the trio reached Columbus, they were stopped and taken in charge by the city marshal. It seems that a car of similar description, con-

taining two men and a woman, had been stolen in Indianapolis the day before. The Columbus police, among others, had been notified of this theft by phone. The city marshal, who had never heard of Dr. Sterne, was waiting for the group as they came chugging into town. Dr. Sterne's protests and indignation alone had no influence on the marshal. Fortunately, Dr. A. J. Banker of Columbus, who knew both the doctor and the marshal, just happened along and verified that Sterne was a physician, not a thief.

Life was less hectic in 1905, but it was not without its problems.

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The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

WINNER
Sandoz Medical Journalism Award—1976, 1979

Vol. 73, No. 1
JANUARY 1980

USPS 284-440
ISSN 0019-6770

POSTMASTER: Send address changes to THE JOURNAL, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

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All issues since 1967 available on microfilm from University Microfilms, Inc., 300 N. Zeeb Rd., Ann Arbor, Mich. 48106. Indexed in Index Medicus and Hospital Literature Index.

Advertising rates and data available on request. Representative for national advertising: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302.

Publication deadline: 1st day of month preceding month of issue.

Subscriptions: \$14 per year, USA; \$16, Canada; \$17, foreign; \$12, libraries; \$10, senior ISMA members; \$8, members; except for special issues, single copies not available. Subscriptions renewable only in January and July.

Second-class postage paid at Indianapolis Ind. and additional mailing office.

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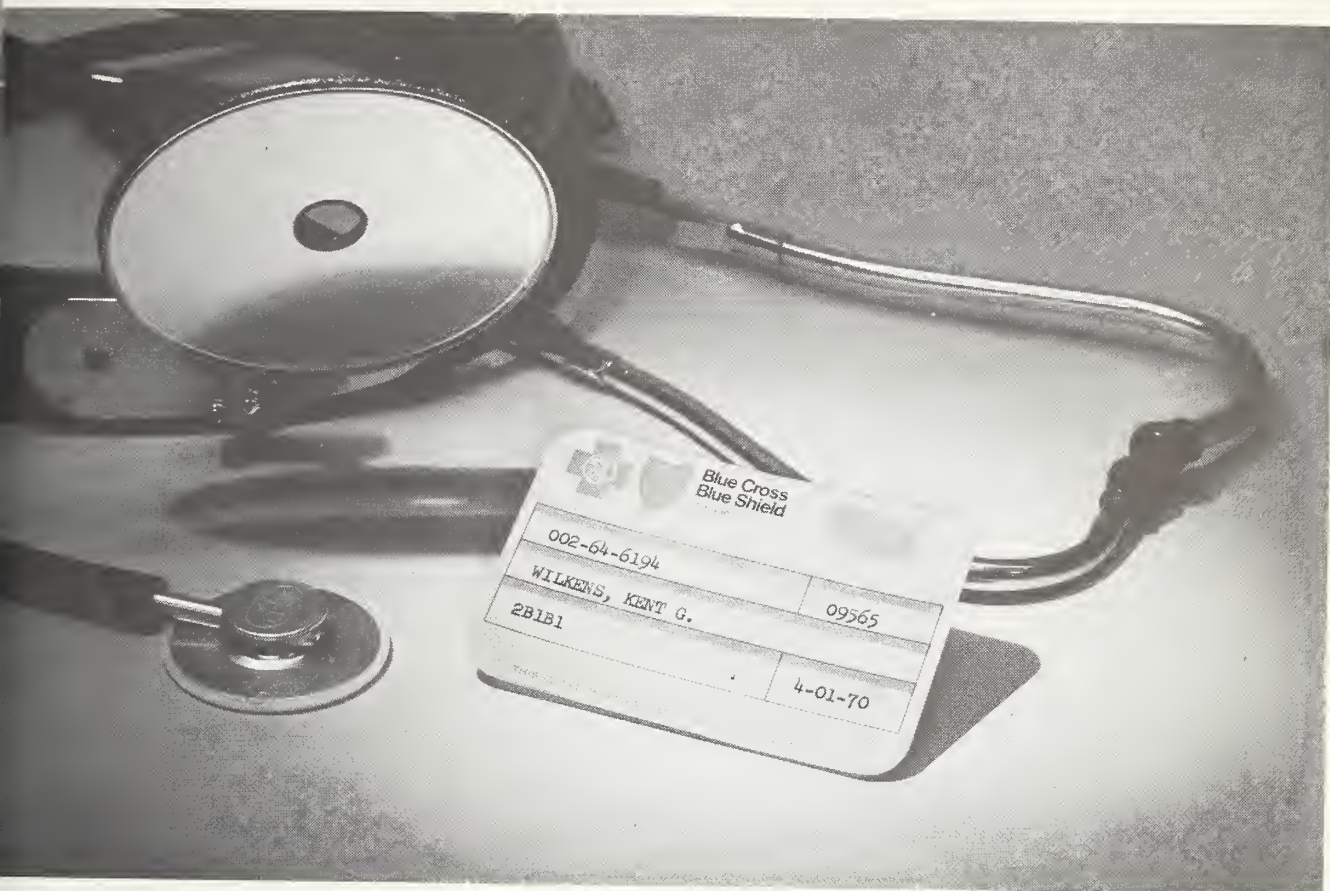
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ABOUT THE COVER

Jamie Moore, son of Mr. and Mrs. Tim Moore of Rockford, Mich., tests his ski mettle on the slopes at Cannonsburg, Mich. Jamie was 4 when the photo was snapped two winters ago by Dr. H. Charles Smith of the Caylor-Nickel Clinic, Bluffton, Ind.



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WHAT'S NEW?

THE DAMON CORPORATION is introducing the Anamod™ series. It is a new line of cross-sectional anatomical models to expedite the learning process for students and patients. Parts of the human body are reproduced on rigid vinyl and printed in four colors. Later models of the reproductive systems, skull, skin, liver, mitosis and meiosis will be available. Economically priced. Come with stand and study/activity manual.

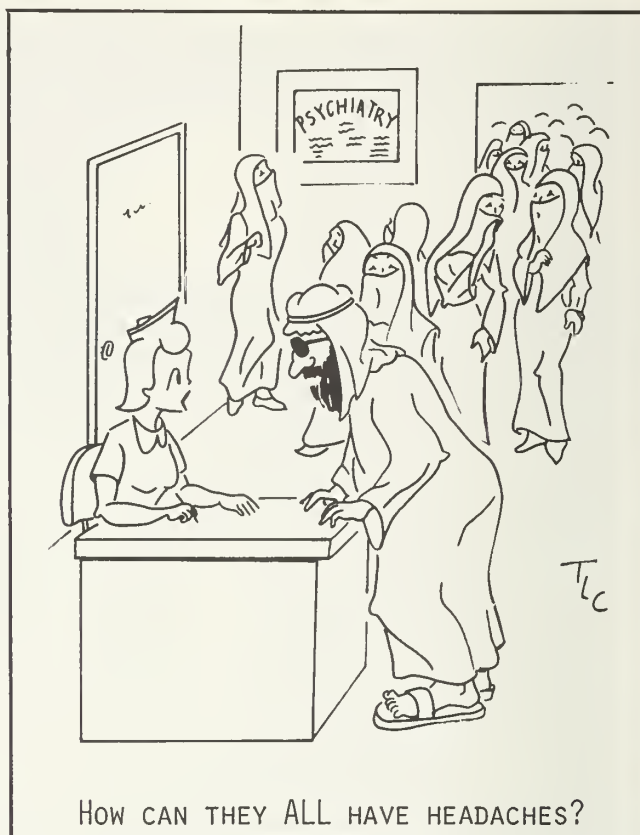
MERCK SHARP & DOHME announces the introduction of a new drug, "Demser" (metyrosine, MSD), for the treatment of patients with pheochromocytoma by controlling elevated blood pressure. The drug is not recommended for control of essential hypertension. It will be classified as a public service drug, one which is expensive to produce, one which serves an important function on a limited number of patients, and which cannot, in good conscience, be marketed at a price that will repay the production cost. MSD will market the new drug at a loss.

THE CENTRAL INDIANA Emergency Medical Services Council, which coordinates service in Marion County and the eight contiguous counties, has arranged for purchase of \$300,000 worth of radio and telephone equipment. It will be used to install a communication system to link the base hospitals in the several counties with each other and with the emergency department at Wishard Memorial Hospital. Paramedics at emergency sites will be able to make contact with the nearest base hospital and Wishard.

DU PONT announces the addition of a fast, sensitive test for creatine kinase MB isoenzyme to the capability of the Du Pont Automatic Clinical Analyzer. The new 'aca' method is the first fully automated system for the important heart enzyme test.

MIDMARK MEDICAL is introducing a new and improved line of seating products, six redesigned physician's stools and a new chair for patients and staff. All physician's stools have 16-inch diameter seats with extra-thick foam padding and vinyl upholstery. Three of the stools have backs. The new chair swivels on a cast aluminum 5-point Stabilizer base.

HEWLETT-PACKARD has a new planning guide designed to assist hospitals in planning the resuscitation cart for cardiac or respiratory needs. It is available free of charge. Describes both standardized and customized systems. The guide includes two worksheets to help plan the number of carts needed. It also includes a list of supplies and equipment. Write to Inquiries Manager, Hewlett-Packard, 175 Wyman St., Waltham, Mass. 02154.



WINNEBAGO INDUSTRIES has introduced two models of Commercial Vehicles for use by medical and health organizations as mobile laboratories. They are fully carpeted and have paneled walls. Can be customized for many uses including: mobile hearing and vision testing units, bloodmobiles, environmental testing, mobile dental facilities, transportation for handicapped, cancer or TB facilities, as a mobile veterinary clinic or as mobile research facilities. One model has 106 square feet of interior space, the other 155 square feet.

THE 3M bur line and 3M air drills are described and illustrated in a new brochure available from the manufacturer. The special line of drills and burs is suitable for bone work in orthopedic, neurological, plastic, reconstructive otorhinolaryngology and oral surgical procedures. Write to SU9-32, Box 33600, 3M Company, St. Paul, Minn. 55133.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by **THE JOURNAL** or by the Indiana State Medical Association.

MEAD JOHNSON is introducing Mucomyst® with Isoproterenol, a new line extension of Mucomyst®. The addition of Isoproterenol provides an effective bronchodilator with the mucolytic action of Mucomyst®. It is packaged in plastic stoppered vials, each containing 4 ml. of solution.

A NEW IBM AUDIO TYPING UNIT helps blind typists work independently. The new unit can "speak" typed information in the form of synthetic speech, allowing the typist to review and proofread material by hearing. The device may be attached to any of four IBM magnetic media typewriters.

MEAD JOHNSON is introducing *Enfamil Premature Formula with Whey*. It will be distributed solely to hospitals. It contains whey-prominent proteins and has a ratio of whey to casein similar to human milk. A blend of fat in the formula provides good fat and good calcium absorption. In addition, the carbohydrates are in a well tolerated, easily digested form.

IN BOOKS...

ENCYCLOPAEDIA BRITANNICA is publishing the fourth *Medical and Health Annual* in 1980. The Annual is written by experts for the layman. More than 60 doctors and other specialists are contributors. There are more than 300 photographs, of which 155 are in color. The 448-page volume is priced at \$15.95.

DOUBLEDAY has released *Drink*, described on the jacket as "a self-help book on alcoholism." The author is a reformed alcoholic, Constantine Fitzgibbon. It is autobiographical and has had many reviews which recommend his convincing personal experience. The book also contains interesting material on the history of alcohol and the human race. 216 pages, \$8.95.

RAVEN PRESS has published *Glutamic Acid: Advances in Biochemistry and Physiology*, a collection of works by 53 international scientists on the safety and advantages of monosodium glutamate as a flavor enhancer. Research and its long-term safe use have resulted in monosodium glutamate being categorized as "Generally Recognized as Safe" by the FDA.

THE E.C.R. COLLECTION has published *Sneezing, Wheezing and Scratching*, a book by Doris Rapp, M.D., designed to serve as a patient aid for physicians involved in the care of patients with allergy, and related respiratory and skin problems. It is generously illustrated with artwork that may be colored by children. For price list and a listing of other books dealing with patient information write The E.C.R. Collection, P.O. Box 615, Los Altos, Calif. 94022.

THE AMERICAN HOSPITAL ASSOCIATION has published *Helping Hospital Trustees Understand Physicians* by Richard E. Thompson, M.D. The 144-page book explains in easy-to-read format the roots of physicians' behavior, motivation, expectations, and professional attitudes. May be purchased for \$11.25 from the Hospital Association.

DOUBLEDAY has released *The Ms. Guide to a Woman's Health* by Cynthia W. Cooke, M.D. and Susan Dworkin. Ms. MAGAZINE initiated the text as a comprehensive guide for women, who are the primary consumers of health care for themselves and their families. Anchor Press publishes a paper back edition at \$7.95. The Doubleday edition is in hardcover at \$14.95.

ANCHOR PRESS announces publication of *Treating Your Hyperactive & Learning Disabled Child: What You Can Do*. The book is produced by the New York Institute for Child Development and is written by Richard J. Walsh. 168 pages, \$8.95. Future File

PRENTICE-HALL announces the third edition of *Words Into Type*, a classic authority on printed form and style, now completely revised with the most up-to-date information on grammar, typography, makeup, word usage, laws of copyright and libel and handling of copy and proofs. 585 pages, \$17.95.

THE JOURNAL

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Physicians' Directory

on

Pages 56-57.

EDITORIALS

You're Right! Something's Different

With this issue, THE JOURNAL introduces a new, higher grade of paper stock to its readers. No longer are we using 50-pound Northcote stock to print the pages of our magazine. What you are looking at is 60-pound Frostbrite matte paper.

We hope you'll like this improvement as we continue to upgrade and modernize the Indiana journal.

Incidentally, our main reason for switching to the new stock is that light doesn't reflect off the pages. Try it. You'll find you can read the articles without having to move the magazine around to eliminate glare.

'Drug Holiday'

Many of our elderly use a large number of over-the-counter and prescription drugs. In reports about nursing homes, we have seen patients on as many as 20 medications. Many of the drugs are needed but some are not. With the half-life of some drugs being one or two days, and the elderly's metabolism reduced, one has to wonder if drugs are being given incorrectly.

Some nursing homes that believe this to be true have experimented with what is called a "drug holiday." With the cooperation of the physician, the nurs-

ing home staff and the patients, the patients are not given drugs on a certain day of the week. This allows nursing staff to spend more time with the patients and, according to some reports, has reduced drug side effects, such as falls and confusion.

Over the long run, if this proves to be a safe approach to drug therapy in the elderly, it will reduce drug costs. It also requires the nursing home to provide more of the tender loving care that is needed by anyone in any kind of an institution.—*Reprinted from ACTION IN PHARMACY, November 1979.*

Recruitment Action Plan

Aid for doctor-short communities is available from the AMA. Although transportation facilities are better than ever today, there are still areas—especially rural areas—large enough in population to require a medical service. Some areas, not sufficiently cared for now, are large enough to warrant a group practice with basic specialists.

In response to this problem, the AMA has prepared an "Action Plan for Physician Recruitment" that provides suggestions and advice for communities in search of medical service. Write to Physicians' Placement Service, American Medical Association, 535 N. Dearborn St., Chicago 60610.

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THE INDIANA STATE MEDICAL ASSOCIATION

1980 Annual Meeting—Oct. 17-20—Indianapolis

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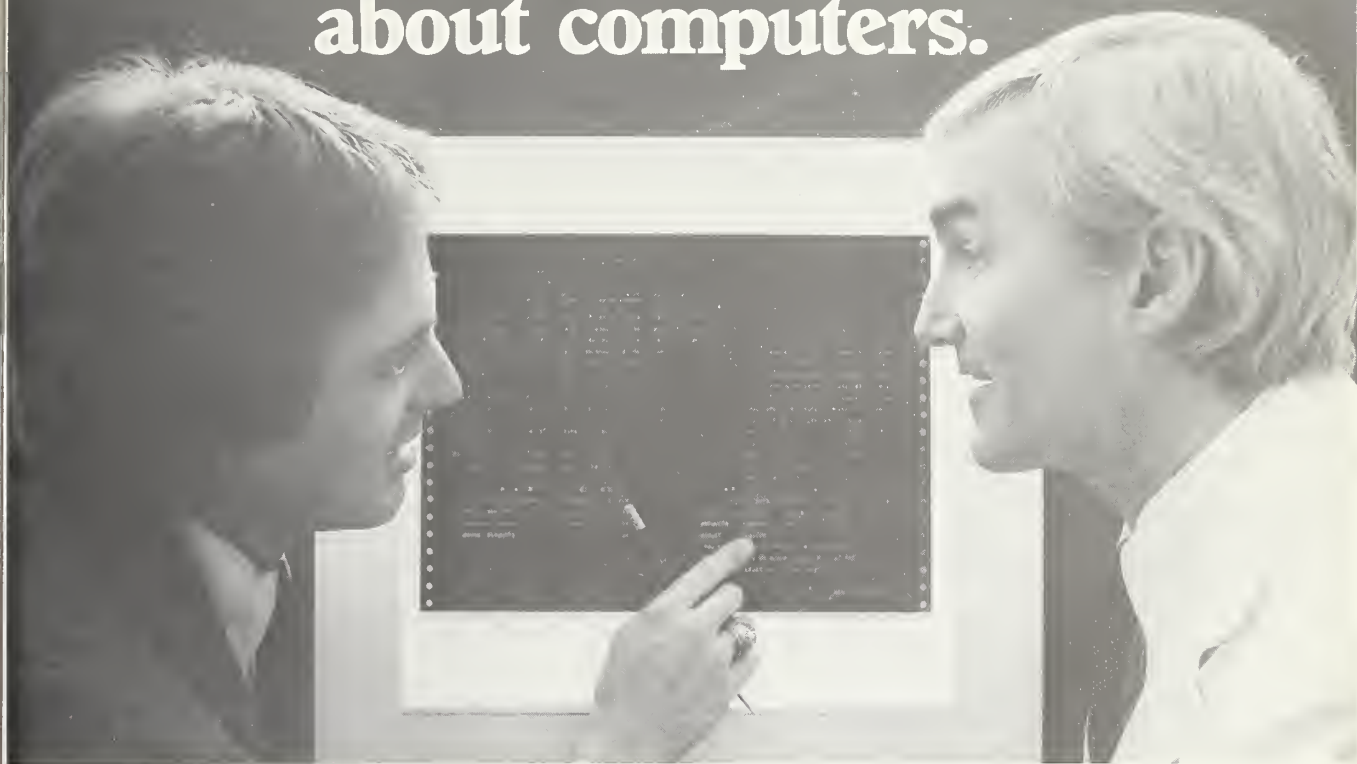
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3—Thomas A. Neathamer, Jeffersonville	Oct. 1982
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9—John A. Knoté, Lafayette (Chairman)	Oct. 1982
10—Martin J. O'Neill, Valparaiso	Oct. 1980
11—Herbert C. Khalauf, Marion	Oct. 1981
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13—Donald S. Chamberlain, South Bend	Oct. 1980

ALTERNATES

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3—Richard G. Huber, Bedford	Oct. 1980
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5—Benny Ko, Terre Haute	Oct. 1982
6—Dan W. Hibner, Richmond	Oct. 1981
7—John D. MacDougall, Beech Grove	Oct. 1982
7—H. Marshall Trusler, Indianapolis	Oct. 1982
8—Richard L. Reedy, Yorktown	Oct. 1982
9—Max N. Hoffman, Covington	Oct. 1980
10—Leonard W. Neal, Munster	Oct. 1982
11—Fred C. Poehler, La Fontaine	Oct. 1980
12—Franklin A. Bryan, Fort Wayne	Oct. 1980
13—John W. Luce, Michigan City	Oct. 1982

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Ideally, data processing could free you from the business side of things so you could concentrate more attention on the practice of medicine.

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EDITORIALS

'Indiana Plan' Produces 42% Hike In Number of Practicing M.D.s

The "Indiana Statewide Medical Education System" has been a success since the beginning. Despite its novelty and unconventional plan, it has accomplished its objectives in an outstanding manner and has become the model for similar systems.

Outside the state the name has been shortened to "Indiana Plan," and is now a guide to many other states and for foreign countries.

Credit for THE PLAN goes to a multitude of people and organizations. The physician shortage of 14 years ago and the migration of well-trained residents to practice elsewhere could not have been corrected but for the basically sound design that originated in the Indiana University School of Medicine and was supported by the university itself.

The financing and legal foundation for the system was furnished by the Indiana Legislature in response to the needs of the state. Other universities and regional campuses of Indiana University are to be congratulated for the manner in which the medical curriculum is now completed in eight Centers for Medical Education outside the School of Medicine in Indianapolis.

The splendid cooperation and hard work of community hospitals over the state have created a great resource of teaching facilities. The medical staffs of

these combination community-teaching hospitals contribute immensely to the medical faculty.

The entire medical education system is tied together through a telecommunication network that operates daily across the state. Doctors can call on the Medical School's WATS line for library services and consultations with faculty members. In addition, programming of the school's two medical television stations regularly reaches dozens of hospitals, health facilities and universities across the state.

No wonder the system is popular elsewhere. Since its inception, 646 additional students have been accommodated. There has been a 37% increase in enrollment of first-year medical students. The number of interns and residents in Indiana hospitals has risen from 428 to 927.

And that's not all. Almost all of the newly trained physicians in Hoosier hospital residencies are practicing in the state. In 1967, 4,800 doctors were in active practice in Indiana—94 per 100,000 population. In 1979, 6,800 doctors were practicing here—128 per 100,000 population. That's an increase of 42%!

Dean Steven C. Beering concludes his progress report on the system as follows: "Indiana citizens can be proud of what they have accomplished in the statewide system. Beginning only as an effort to resolve a regional problem, the program has become a guidepost for others wrestling with the shortage of doctors around the world. Thus, in Indiana, the pioneering spirit lives on!"

Nobel Prize for CAT Scanner

Godfrey Newbold Hounsfield and Allen MacLeod Cormack, co-inventors of the CAT scanner, have received the Nobel Prize for their accomplishment. The citation states: "No other method within x-ray diagnostics within such a short period of time has led to such remarkable advances in research and in a multitude of applications." It is a good thing HEW and its fuzzy headed medical planners are not in charge of the Nobel Prize program.

Billions Needed to Finance Prescription Drug Coverage

In a study made possible by a grant from Roche Laboratories, it has been determined that from \$2.6 to \$18.3 billion in new taxes would be necessary to finance prescription drug coverage under a national program. The cost varies with the size of the population to be covered, scope of the drugs to be reimbursed and cost-sharing.

The big figure covers the cost for the entire population for all outpatient prescriptions, with patients paying \$2 for each prescription.

A highly competent actuary, Gordon R. Trapnell,

Fellow of the Society of Actuaries, and at one time senior actuary for the Social Security Administration, conducted the study.

Research Shows Dopamine May Improve Movement

Research by the National Institute on Aging indicates that disturbances in movement observed in old age are probably due to age-related changes in the central nervous system and that the process may be reversed by administration of L-dopa or apomorphine (a dopamine receptor stimulant). Aged rats with disturbances of movement are improved dramatically by dopamine.

Insulin Strength Changeover

The U-80 strength of insulin will no longer be certified by the FDA after March 24. U-100 strength has been available since 1973 and after the cutoff date will be the only high concentration preparation. The U-100 strength is advantageous because any given dose will be contained in a smaller volume and can be given with less discomfort. Both disposable and glass syringes, calibrated for U-100, are available.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-7-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male, 1. Eunuchoidism and eunuchism 2. Male climacteric symptoms when these are secondary to androgen deficiency 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Cutting Hospital Costs

Guest Editorial

L. A. ARATA, M.D.
Shelbyville

Since the current great worry of the money wasters of Washington, D.C. is the high cost of health care (meaning high hospital costs), and since controlling such costs is a necessary prelude to leading Americans into the Promised Land of Government Medicine, I offer my solution to the problem. Utopia may soon arrive via the "Arata Low Cost Hospital Plan."

For easy mathematics, let us assume the average cost per hospital day is \$200 and see how we can cut this down. Housekeeping amounts to about 2.5% = \$5/day. Let the patient or his next of kin tidy up his room and clean the bathroom. With only the corridors to care for, we save \$4 daily.

Laundry and linen are to be furnished by the family; net savings \$3.50/day. Food and dietary workers eliminated entirely. The family brings in food, or the telephone hot line to Colonel Sanders or McDonald's delivers delicious hot meals at the ring of the phone: net savings \$15 daily. If we can rent space to the caterer, we might increase hospital revenue and cut our costs another \$2/day.

The same hot line phone to the pharmacist on the corner, or to the one who leases space in our

hospital, cuts our bill another \$9/day. Patients are responsible for their own insurance forms and paperwork saving 3/4 of the office payroll and saving \$15 daily. To cut insurance rates, we put our mattresses on the floor. No more falling from bed, and malpractice claims save another \$2.50.

Employee benefits and salary expense reduced by \$13 by reducing number of employees needed. OB eliminated by locating our hospitals where there will be fewer than 500 deliveries a year saves another \$4. With fewer nurses, reduce nursing administration \$5. Patients supply their own band-aids, tape, dressings, thermometers, soap, toilet paper, etc.; save \$20. With little to audit and no litigation, these costs will be reduced \$1.

Already, we have cut our bill to \$100. With imagination and careful thought, we can eliminate many other expenses. Since most surgery is unnecessary, with a plan of 7 or 8 opinions, we can eliminate the surgery suite entirely, or cut it down to two 1/2 days a week. By locating our economy hospital not too far from a conventional one, we eliminate the Emergency Room service. Careful negotiations with the pharmacists and food purveyors provide money-paying leases to help defray the unavoidable costs of running the hospital.

Having arrived at this wonderful solution to the insolvable problem of high hospital costs, I am in a quandary as to how to proceed. I ponder the pros and cons of franchising the operations and growing very rich—or seeking fame and status peddling the idea to the Fuzzy Thinkers of Foggy Bottom. After this brainstorm, I think I may be more at home among the FT of FB than among the Filthy Rich.

LETTERS

Thanks ISMA Staff

(The following letter from the immediate past president of the Ohio State Medical Association was directed to Donald F. Foy, ISMA executive director.)

My wife Alma and I thank you and all the staff members of the Indiana State Medical Association for the many kindnesses and courtesies shown us at your recent meeting (annual convention).

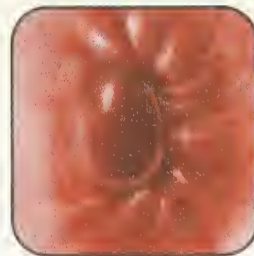
The meeting was well planned, well organized and very efficiently run. It was indeed a pleasure to attend such a meeting.

The members of your staff were at all times friendly, were extremely helpful and seemed to go out of their way to be exceptionally nice. It was very much appreciated.

JOHN J. GAUGHAN, M.D.
Cleveland, Ohio

Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is encouraged. Letters should be addressed c/o THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani. Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC[®] Suppositories and Anusol-HC[®] Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnosis or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Core should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning

and one of bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

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Waiting Room Blues

Guest Editorial

ERNEST LACHMAN, M.D.†
Oklahoma City, Okla.

A friend, who at predetermined intervals is admitted for specific periods to a large city hospital, has to sit each time for hours in the waiting room before her file is processed and she is admitted to her ward. On her last admission, her husband, an executive of excellent credit rating, tried to relieve her of this strenuous and stressful admitting procedure while the patient waited in the nearby home of a friend. This was not acceptable to the admitting clerk. Her husband had to bring the patient after all and she had to wait her turn, just as before.

My personal experiences have been better and might suggest a different solution to this problem. I was admitted immediately to my room, later a clerk came to obtain the necessary fiscal data regarding insurance, etc. Analogy with a hotel which receives preregistered guests or tours without great delay seems appropriate.

Recently, I experienced another upsetting example of improper conduct of waiting room personnel in a specialty clinic. Patients were called only by their last names without prefix "Mr" or "Mrs," as if they were in an immigration office dealing with undesirable aliens. One of my pet peeves is secretaries or clerks who, in a well-fitted waiting room, tell each other their private jokes, accompanied by laughter or show their hobby project such as samples of cloth, etc. Once I entered the waiting room of a physician friend for a consultation. The secretary, being engaged in a telephone conversation, pointed to a chain and continued the dialogue with her friend for another 15 minutes during which she discussed the most trivial events of her past week.

Some years ago I had to see a specialist at frequent intervals. My appointment was generally at 4 p.m., the last of the day. When the physician had finally worked his way through the large number of patients waiting for him, my turn came at about 6 p.m. The physician seemed

completely spent and my complaints faded into relative insignificance in comparison to his exhaustion. The primary need for both of us appeared to be to get home as quickly as possible.

Another friend told me that for several months he visited a specialty clinic run by a number of physicians. The receptionist, who seemed to be a different person each time, always directed to him the following two questions: "What is your name?" and "Is this the first time you have been here?" He finally answered the latter to himself ". . . and the last time!" and changed doctors.

These examples suffice, but could be supplemented by many others. By contrast, I have encountered numerous receptionists and secretaries who handle patients with warmth and affection and make serious attempts to relieve them of their anxiety and tension so that they approach the physician's office in a better frame of mind than when they came in.

I wish hospital administrators and physicians could, like Calif Harun al-Rashid, in disguise and unbeknownst to their personnel, sit in their own waiting rooms and observe the behavior of their staff.

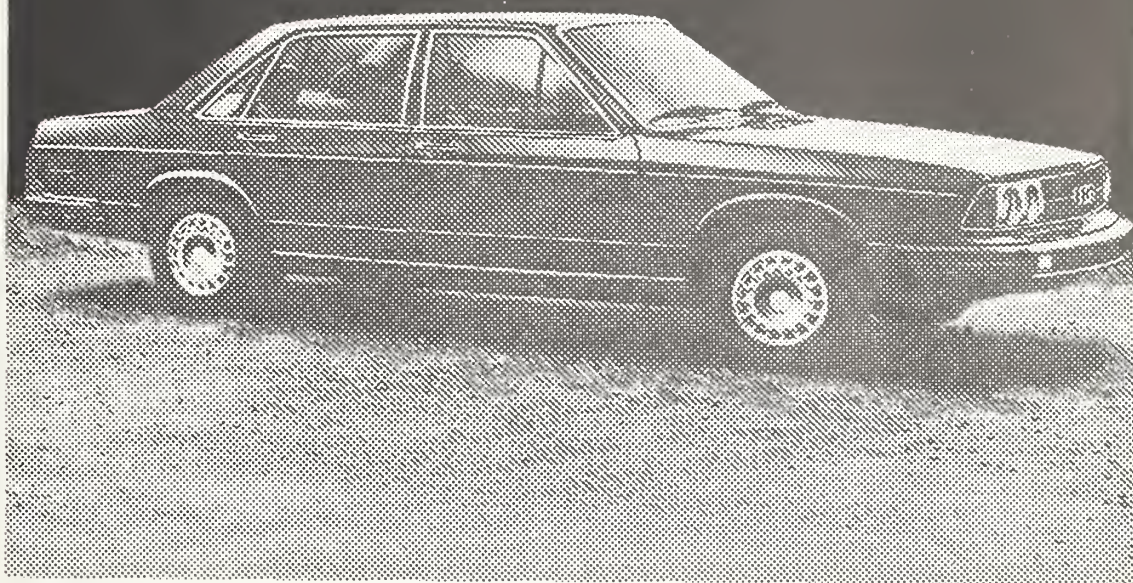
What can we do about this often quite unhappy setting, being aware that waiting patients are frequently in a state of increased anxiety and foreboding, or, at best, tense and nervous? We know that the waiting room experience will greatly affect the patients' rapport with the physician, particularly on their first visit. If they bring with them a pleasant feeling of relaxation and good humor, the battle is half won. The physician should stick to a reasonable time schedule, avoiding long periods of waiting for his patients. The ambience of the room, which might include plants, paintings and comfortable chairs, should calm the patient's tension. Small children and male adults are not very compatible in a waiting room.

Patients should always be addressed by their names to personalize their relationship. The receptionist and/or secretary should be made aware by example and instruction that for humanitarian and practical reasons all waiting patients should be made to feel as comfortable as possible. Hospitals and clinics should introduce on-the-job-training in this field for their staffs, bringing to their attention that in general patients are more sensitive and anxious than the people they meet in ordinary walks of life.

But, first and foremost, physicians, hospital administrators, nurses, technicians, administrative staff, and, yes—even biomedical science teachers, should realize that the only reason for their professional existence is the patient.

†The author, who died in September 1979, was Corresponding Editor of The Journal of the Oklahoma State Medical Association, in which this editorial was published in October 1979. Dr. Lachman had been Regents Professor Emeritus of Anatomical and Radiological Sciences, University of Oklahoma Health Sciences Center.

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Separation of Powers

Guest Editorial

DAVID A. SMITH, M.D.
Lemoyne, Pennsylvania

Joseph Califano, the former secretary of HEW, at the annual meeting of the American Bar Association, criticized the involvement of the federal courts in the operation of HEW. He charged that the courts represent a powerful and unaccountable bureaucracy; that HEW function is inhibited by continuing court orders; that the courts are not concerned with cost containment or other efficiencies in management. He feels that the country would benefit from a "penetrating examination" of the courts, especially regarding the "fair and efficient administration" of social programs. This statement implies an intent to alter, in some fashion, the federal judiciary system.

Califano cited a number of examples which he felt showed judges interfering in the operation of the department and, in general, meddling in matters clearly claimed by the executive arm of government. His reasoning is that the Constitution provides for separation of powers of the three branches of government. One branch should not assume the duties and responsibilities of another. On the other hand, while the Constitution carefully delineates the powers of each branch, each has grown with interpretation and has developed through tradition. The courts, fortunately for us, are included in this respect.

Alexander Hamilton introduced what has come to be called the doctrine of "implied powers" based upon the Constitutional clause which states that Congress may pass laws that are "necessary and proper" to carry out its "enumerated powers." The Constitution provides that judicial power belongs to the federal courts and that this power "shall extend to all cases, in law and equity, arising under this Constitution, the laws

of the United States . . ." John Marshall, the first and probably most famous chief justice, borrowed the Hamiltonian concept in his famous decision in the case of *Marbury vs. Madison* (1801), which established judicial review as a function of the court. Although this concept is not specifically provided in the Constitution, it is implied. Congress cannot legislate that which conflicts with the Constitution.

During the mid-1950s to the mid-1960s the Warren court handed down a number of unpopular social decisions. Rulings against required prayer in public school, for desegregation of schools, and for reapportionment, increased feelings against the judiciary. It is apparent now, even if it was not then, that this court was protecting the rights of the individual.

Some of the continuing court orders which Mr. Califano protests are in this tradition. HEW, for example, was prohibited from publishing names of Medicare physicians and the dollar income they receive from the program. The greater good as perceived by those in power cannot be bought by the sacrifice of rights of individuals.

Fisher Ames, a Harvard educated lawyer who realized the necessity of protection of the rights of individuals, wrote in 1805:

"There may be a tyranny of the many as well as the few. The people, as a body, cannot deliberate. Nevertheless, they will feel an irresistible impulse to act and their resolutions will be dictated to them by demagogues . . . To make a nation free, the crafty must be kept in awe, and the violent in restraint. The weak and the simple find their liberty arises not from their own individual sovereignty, but from the power of law and justice over all. It is only by the due restraint of others, that I am free . . ."

Even Presidents who have dared to entertain ideas of altering or intervening in the judiciary system have recognized the value and tradition of the courts. The judicial system does not need a "penetrating examination," but perhaps a department subjected to more than 225 continuing court orders and involved in more than 1,600 lawsuits would benefit from just such an examination.

The judicial system is not responsible for the woes of HEW. The laws are there; the courts interpret.

The author is Medical Editor of PENNSYLVANIA MEDICINE, in which this editorial appeared in November 1979. Reprinted with permission.

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Physician's Involvement in Indiana Health Systems Agency

Guest Editorial

J. FRANKLIN SWAIM, M.D.
Rockville, Ind.

I recently read that the Indiana State Medical Association wanted names of physicians who would be interested in serving on the board of the Indiana Health Systems Agency, Inc. From my experience, the involvement of private physicians on these boards is vital to the survival of the private practice of medicine in Indiana as well as the United States.

I started serving on the Terre Haute Sub-Area Advisory Council last May. Prior to that time, according to one of the board members, all requests for state and federal funds to finance government health programs had been approved since the inception of the Southern Indiana Health Systems Agency and the local council.

There was recently a request for approximately \$240,000 to fund a program for unwed mothers and teenage pregnancy counseling. At the local council meeting I said this was an unneeded duplication of services. From my experience, these people have been adequately cared for by their family physicians, the local welfare office, and by their family all working together. Furthermore, Planned Parenthood also is active in this area. I could see no reason for getting another bureaucracy involved.

The Sub-Area council agreed and sent the recommendation to the Southern Indiana Health

Systems Agency, which also concurred. The request was not granted.

Funding this program would have diverted patients away from the office of private practitioners of medicine. It also would have undermined the patient-physician relationship because it would offer alternative channels through which patients could receive medical help, subsidized by American taxpayers and provided by people other than qualified physicians.

Several members of the board, including the chairperson, were absent from this meeting. They were upset by the decision of the board, and I'm sure if it came up for vote again, they could have mustered enough votes to have overturned that decision. The local board, as a group, seems very sympathetic toward government intervention and a governmental takeover of all medical services. There seem to be very few members sympathetic toward private enterprise generally and private medical practice specifically.

Last August a county health department requested a \$16,000 grant to supply flu shots to those over 65 years of age. This issue was hotly debated at the Sub-Area office and I again maintained this was a duplication of medical services. This group of people is quite capable of obtaining flu shots from family physicians and are financially capable of paying for them. Some of these people are on Medicaid and are provided for anyway. All of them are on Medicare, and this is a reimbursable cost under Medicare once they have met their deductible. This is another example of an infringement upon the private practice of medicine by a governmental bureaucracy that wants to provide the service.

The local board voted in favor of the County Health Department being granted this \$16,000 with which to set up and operate this immunization program. However, when referred to the Southern Indiana Health Systems Agency, they disagreed with the local council's decision and refused to grant the money. If there had not been some opposition expressed at our local meeting, and the reasons so stated, the regional board probably would have gone along with the Sub-Area council.

Serving on these Health Systems Agency boards gives the physician a unique opportunity to do something about the intervention of the federal and state government into the private practice of medicine. Physicians who want to see such a system survive and perpetuate itself should serve on these boards.



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Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

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Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin: used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

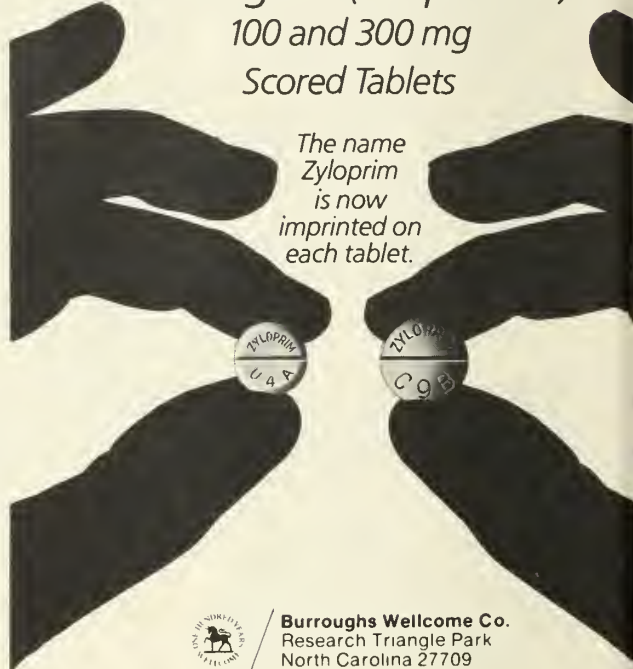
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To obtain Category I credit, complete the quiz on Page 45.



Understanding the Sleep Apnea Syndromes

THE SLEEP APNEA SYNDROMES comprise a group of disorders that have in common repeated episodes of non-breathing during sleep. There are three basic sleep apnea patterns:

- The central type, which presents as the intermittent cessation of breathing in the absence of respiratory effort; it may be ascribable to a known central nervous system problem but is usually of idiopathic origin;

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- The obstructive type, which also has stoppage of airflow at the nose and mouth, yet breathing efforts are maintained, often to an extreme degree; in all cases there is obstruction in the upper airways and all too often no detectable anatomical defect;

- The mixed, or complex type, which is the most common pattern seen; there are elements of central

and obstructive apnea in each episode.

Clinical testing methods for sleep apnea (polysomnography) are very good for detecting its presence and defining the apnea type. They have become increasingly utilized recently. Because there are different sleep apnea patterns and the possible etiologies for each are diverse, it should come as no surprise that their treatments differ markedly. Hence, today it is important for the clinician to be able to detect clues for the occurrence of sleep apnea from the history and physical examination and to have a working idea of how to proceed with evaluation. Once the underlying disorder has been described, then many times specific therapy may be instituted. This article is designed to help the practicing physician meet these objectives.

Victims of Sleep Apnea Syndromes may be constantly sleepy, chronically tired, short of breath or sexually impotent. They may have morning headaches or nocturnal insomnia. Or they may be loud snorers. . .

NORMAL SLEEP

Sleep is not a steady-state event. By utilizing electroencephalographic (EEG), electro-oculographic (EOG), and electromyographic (EMG) tests, and by observing behavior, two basic patterns of sleep have been defined. Non-rapid eye movement (non-REM) sleep normally occurs first, progressing through four succeeding deeper stages and lasting 1½-2 hours. This is followed by 20 to 30 minutes of rapid eye movement (REM) sleep, which itself has two components: active, characterized by short bursts of voluntary and involuntary muscle activity; and inactive, which has suppression of muscle tone. The

non-REM/REM sleep cycle repeats itself several times each night with about 25% of sleep spent in the REM phase. Imaginative and uninhibited dreaming tends to occur during REM sleep, while dreams during non-REM sleep seem to relate to activities of the day.

The control of breathing during both the sleep and awake states is thought to be regulated mainly through two separate but interrelated neurological systems. One is the voluntary, or behavioral, system originating in cortical and fore-brain structures. The other is the automatic, or metabolic, system, which consists of elements in the brainstem structures of the pons and medulla oblongata.

Normally, in the awake state respiration is maintained by both of these systems. During the deeper stages of non-REM sleep, metabolic factors such as pH, pCO₂ and pO₂ totally determine the breathing pattern by their influence on the metabolic system. In contrast, during the active phase of REM sleep breathing is irregular, and metabolic control is markedly diminished with presumably "behavioral" mechanisms in charge. Light non-REM sleep and the tonic, or inactive, phase of REM sleep have both control systems operative. It is important here to realize that sleep is not a homogeneous process, for during it there are changes in many different organ systems, several of which are poorly understood at present. There are many excellent discussions for the interested reader.

SLEEP DISORDERS

Sleep-related complaints are among the most common encountered in modern medicine. Although dealing with the huge spectrum of sleep disorders is beyond the scope of this article, it should be appreciated that sleep apnea is only one cause of sleep problems. Insomnia, the inability to sleep or stay asleep, is the most common sleep complaint and often has an underlying medical cause (e.g., chronic pain, acute illness).

Next in frequency is disturbed sleep. It may have definable causes such as nocturnal wheezing or coughing due to asthma. In addition, chronic pulmonary aspiration is a frequently asymptomatic and overlooked problem. Paroxysmal nocturnal dyspnea from chronic obstructive lung disease or congestive heart failure and nocturnal chest pain from coronary artery disease will naturally disturb a patient's sleep.

Cheyne-Stokes respirations (periods of central apnea with a return

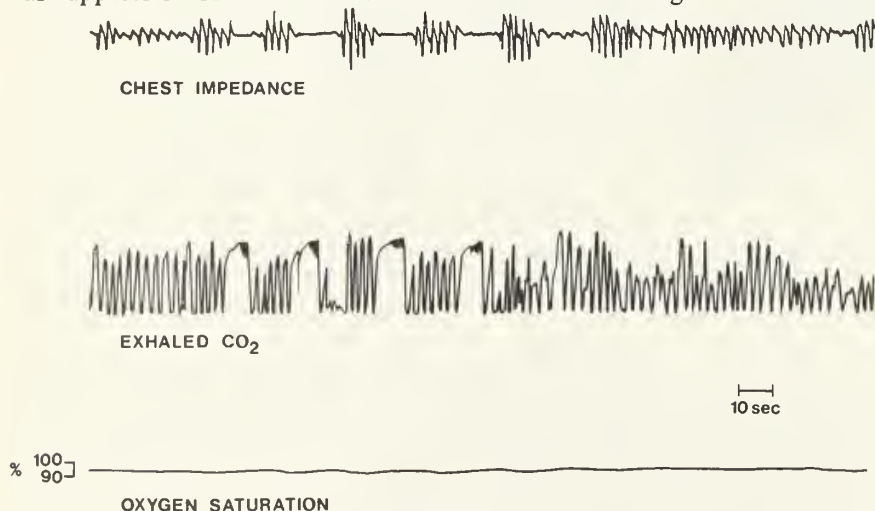


FIGURE 1

Sleep tracing showing examples of central sleep apnea. An impedance pneumograph* is used to monitor respiratory effort. The 15-30 second periods of electrical "silence" in the top tracing indicate a complete lack of respiratory effort; the exhaled CO₂ tracing shows no inspiratory falls during these times. The oxygen desaturation is mild but detectable. There is no obstructive apnea.

*Hewlett-Packard 78212A Automatic Respiration Module

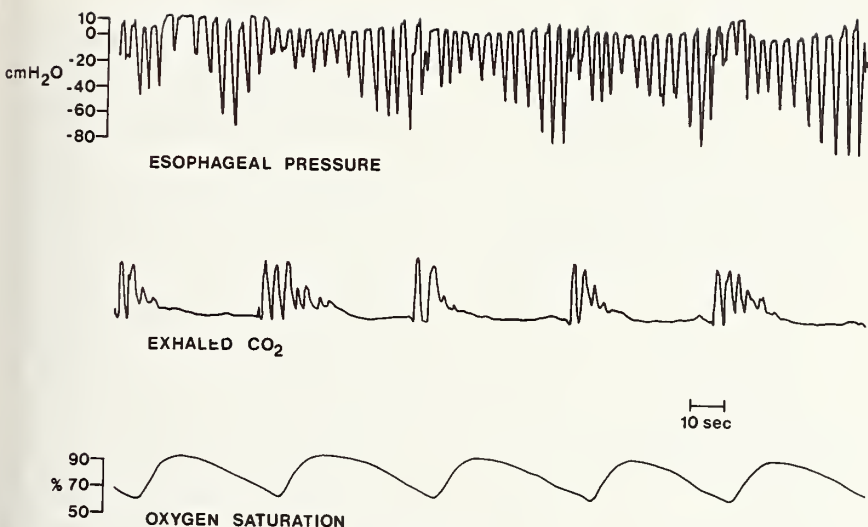


FIGURE 2

Sleep study tracing showing repetitive obstructive apnea. In each episode notice the increasing negativity of esophageal pressure, the absence of airflow and the associated severe oxygen desaturation. There is no central apnea.

to increasingly deeper breathing to the point of hyperventilation, followed by apnea and the cycle repeated) can alter the sleep of the patient or that of the partner. This type of breathing pattern may be seen in patients with cerebrovascular disease, severe congestive heart failure, chronic obstructive pulmonary disease and bilateral pyramidal tract destruction.

Respiration-stimulant medications (see below) may help restore a normal breathing pattern. In contrast, sleep disturbances caused by enuresis, sleep walking and nightmares tend to occur in children, dissipate with advancing age and may not be associated with serious medical problems.

The least common sleep disorder is daytime hypersomnolence, excessive sleepiness during normal awake hours. Yet, it is the usual complaint in patients with sleep apnea syndromes, narcolepsy, disrupted circadian rhythms (e.g., "jet lag"), stimulant/sedative drug abuse, hypothyroidism and many more. It needs to be stressed that psychiatric

problems such as anxiety/depression or psychosis, in both acute and chronic forms, are the most frequently blamed causes of the three sleep aberrations: insomnia, disturbed sleep and daytime hypersomnolence.

SLEEP APNEA SYNDROMES

Definitions and Terms: Apnea is

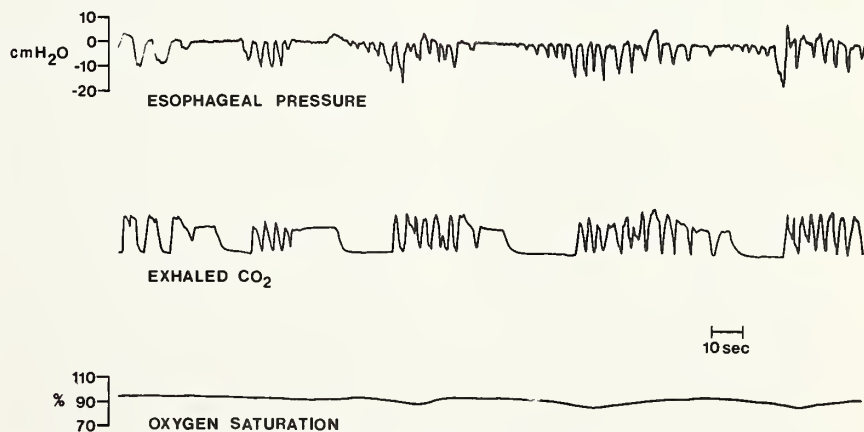


FIGURE 3

Sleep tracing which demonstrates mixed, or complex, apnea. The first event, far left, is entirely central. The next three are mixed in that there is initial loss of respiratory effort followed by obstruction to airflow. Oxygen desaturation occurs at the end of each episode.

operationally defined as the complete cessation of airflow at the nose and mouth for at least 12 to 15 seconds. As noted above, the sleep apneic event is either central, obstructive or mixed. It may be detected through testing, which simultaneously monitors sleep stage, respiratory effort, airflow at the nose and mouth, and arterial oxygen saturation. *Figures 1-3* graphically represent the three types of sleep apnea. Though not shown, all three tracings are during stage 2 non-REM sleep, defined in a conventional manner.

Most cases of central sleep apnea (*Figure 1*) are thought to be due to intermittent failure of neurons to discharge in the automatic respiratory control centers in the brainstem. Alternatively, failure of the nerve impulse to propagate to the respiratory muscles and/or failure of the respiratory muscles to act once the impulse reaches them might be possible factors in some central apneas.

Idiopathic obstructive sleep apnea (*Figure 2*) is likely the result of phasic loss of tone in muscle groups of the upper airways. Electromyographic studies have impli-

cated muscles controlling the tongue, the posterior pharynx, the glottis and larynx in part and in combination. The loss of muscle tone is thought to be due to intermittent CNS dysfunction, for example, in upper or lower motor neurons or their feedback mechanisms.

The mixed type (*Figure 3*) is the one most commonly seen in sleep apnea study centers. While the central and obstructive aspects may arise concurrently, a popular theory holds that the upper airways obstruction occurs first (which itself may be of central origin) and that repeated episodes of hypoxemia during sleep over a period ranging from months to years results in damaged CNS respiratory centers. This eventuates into a central component, making the episode mixed. One consistent finding seen in all mixed apneic events is that the central component always precedes the obstructive one. In all-night sleep recordings, it is usually the case that all three types of apneic events occur in each patient during each night with one type being predominant.

Presenting Symptoms: *Table 1* lists the clinical heterogeneity with which the sleep apnea syndromes may present. While recent studies suggest that asymptomatic sleep apnea may be common in males, the majority of patients studied to date with the disorder have a sleep-related complaint. Daytime hypersomnolence is most common; however, up to 10% of patients present with insomnia.

Obesity is frequent, but it is by no means a prerequisite for the disorder, as previously thought. The patient's sleep is usually disturbed with frequent arousals, there being on an average hundreds of apneic episodes per sleep period. Perhaps a bed partner or parent will have witnessed the apnea. Dreams of being paralyzed while falling into

TABLE 1
Clinical Presentations of
Sleep Apnea Syndromes

Daytime hypersomnolence
Loud snoring, frequently excessive
Apneic episodes during sleep
Abnormal movements during sleep
Disturbed sleep (arousals, nightmares, etc.)
Morning headache
Altered awake behavior (work problems, etc.)
Chronic fatigue
Shortness of breath
Near-sudden-death as infant
Nocturnal insomnia
Nocturnal enuresis, particularly children
Sexual impotence

or coming out of sleep (sleep paralysis) and visual or auditory hallucinations during sleep (hypnagogic hallucinations) are peculiar complaints to this disorder and its clinical masquerader, narcolepsy.

Cataplexy, sudden decrease or loss of muscle tone that may be generalized or confined to individual muscles, is also a symptom common to both disorders. Indeed, patients rarely have both narcolepsy and sleep apnea. The often-met-with complaints of chronic fatigue, morning headache and altered awake behavior seem to go hand-in-hand with the daytime hypersomnolence.

Even though snoring seems to be ubiquitous in the general population, in its mildest form it signifies some degree of upper airway inspiratory obstruction. Thus, excessively loud snoring is one of the most reliable symptoms of obstructive sleep apnea. It is not uncommon for patients to be heard snoring throughout their homes and disturbing even their neighbors. Questioning the patient about his personal life may reveal marital discord due to the disquieting symptoms.

It is speculated that sleep apnea is commonly either a causal or precipitating event in adult and infant sudden death. Interestingly, patients who have had near sudden death episodes as infants typically go for decades before presenting with symptoms of sleep apnea, so called Ondine's curse or idiopathic hypoventilation. Familial clustering of sleep apnea cases has been documented, but does not seem to be common.

Common Findings: Obesity is seen in half to two-thirds of the patients in large studies. It need not be excessive (*Table 2*). More importantly, it is advisable for the physician to observe the hypersomnolent patient sleeping. This is easily done in an office setting because of the patient's excessive sleepiness and frequent apneic episodes during sleep. During mixed apnea the patient is at first totally quiescent, with no airflow at the nose or mouth. This central component lasts for a variable time (15-40 sec.) and is followed by increasingly deeper respiratory efforts. The absence or marked reduction of airflow continues, yet there are thrusting movements of the chest and abdominal wall muscles as the patient tries to overcome the upper airway obstruction. While totally obstructed he makes little noise. The snoring seems to reach a crescendo after the obstruction is relieved.

During recovery the patient frantically hyperventilates for several breaths as if he had just been suffocated. The total mixed episode generally lasts 30-60 seconds. There follows a variable and usually short period of normal breathing with another apneic episode beginning soon thereafter. Pure obstructive apneas lack only the initial central features. The central ones do not have the respiratory thrusts and

loud snoring noises. They also seem to have less motor activity and hyperventilation upon recovery.

Wheezing or its more severe form, stridor, which is heard over the trachea but not throughout the chest, is a good sign of upper airway obstruction. However, it is infrequent. In patients with obstructive apnea a search for lesions in the upper airway and neck is essential. Adenotonsillar hypertrophy, lymphoma, acromegaly, goiter, micrognathia, temporomandibular joint disease, myxedema and squamous cell carcinoma are some of the documented causes of obstructive apnea. Musculoskeletal disorders, such as the myotonic dystrophies, can be associated with obstructive sleep apnea due to loss of tone in upper airway muscle groups. Moreover, lung ventilation may be inadequate because of affected respiratory muscles.

Central-type sleep apnea may result from deranged CNS respiratory centers due to:

- Drug intoxication (alcohol, narcotics, tranquilizers);
- Direct damage to those structures by bulbar poliomyelitis and encephalitis;
- Brainstem infarction;
- Neoplasm;
- Damage to the cervical cord via surgery or trauma.

Usually the cause of the central sleep apnea syndrome is not known. Patients with non-specific hypoventilation while awake, either from CNS disease (e.g. Guillain-Barre syndrome) or abnormalities of the breathing apparatus itself, have even more trouble maintaining lung ventilation while asleep.

Systemic hypertension is common in sleep apneic patients. The sympathetic response to frequent hypoxia is thought to be responsible for its development. Pulmonary hy-

TABLE 2
Common Findings in Sleep Apnea Syndromes

Obesity, may be mild or absent
Upper airway obstruction
Central nervous system dysfunction, including drug intoxication
Musculoskeletal disorders
Systemic hypertension
Pulmonary hypertension, *cor pulmonale*
Congestive heart failure
Cardiac arrhythmias
Polycythemia
Idiopathic alveolar hypoventilation
? Chronic obstructive pulmonary disease

pertension develops during the night in these patients and if maintained for a long period may result in *cor pulmonale*. Congestive heart failure may develop due to long-standing systemic and pulmonary hypertension. Cardiac arrhythmias during the apneic episodes are very common; they tend not to occur when the patient is awake. Oxygen desaturation to some degree invariably occurs toward the end of each episode. It seems to be more severe in patients with obstructive apnea. The arterial carbon dioxide tension rises at the end of each episode reflecting the alveolar hypoventilation. Chronic hypoxemia at night may result in polycythemia. Several studies have suggested that patients with chronic obstructive lung disease have frequent episodes of apnea of all types at night, particularly during REM sleep.

Evaluation: Sleep apnea should be suspected in any patient who has a sleep disorder and/or the apneic-type complaints mentioned earlier. The diagnosis is usually not difficult to establish. The usual data base should be obtained including complete blood count, electrocardiogram and chest x-ray. Metabolic profile of the patient (blood glucose, thyroid hormone, serum corti-

sol, chem 12, drug levels, etc.) may be helpful, particularly if the reason for the sleep disorder is not apparent. Pulmonary function testing should be done to rule out awake ventilatory deficits.

Patients with sleep apnea syndromes without pre-existing lung disease and without extreme obesity commonly have normal lung function, though there may be evidence of upper airways obstruction. An arterial blood gas should be obtained to assess oxygenation and pH. Also, the arterial pCO_2 is an excellent indicator of the level of ventilation, an elevated pCO_2 being the *sine qua non* of alveolar hypoventilation. A sleep EEG is mandatory to rule out narcolepsy. Typically, narcoleptic patients go right into REM sleep, yet up to 25% of such patients may have a normal sleep recording. Additionally, neurological evaluation to exclude associated CNS disease is necessary in patients with central apnea.

While it is crucial to evaluate for disorders associated with the sleep apnea syndromes, it is just as important to be able to define the type of apneic event that most often occurs in a given patient. Fortunately, there is usually one type that occurs most of the time. The type of sleep apnea is determined by continuously monitoring the following during sleep:

- **Respiratory effort** using either an esophageal balloon (esophageal pressure fluctuations reflect pleural pressure changes) or an impedance pneumograph, which reflects chest wall movement;

- The presence or absence of *air-flow* as determined by an airflow thermister at the nose and mouth or a sensitive CO_2 analyzer at the same points;

- **Oxygen saturation** measured by an ear oximeter or from individual determinations drawn from an indwelling arterial line.

Episodes of complete sleep apnea are not difficult to detect (See *Figures 1-3*); however, many times oxygen desaturation occurs in the absence of a definable apneic event. In most of these instances, it happens in the setting of increased respiratory effort, which is taken as a sign of partial upper airway obstruction. Hypopnea is defined as both a marked decrease in respiratory effort and a rate decrease down to about six breaths per minute. It is thought to be an incomplete form of central apnea.

Sleep staging using criteria mentioned earlier should be performed concomitantly in all patients so that narcolepsy is not overlooked. Additionally, objective evidence for both the sleep and awake state is then readily at hand. All-night sleep recordings are desirable; nonetheless, daytime "nap" studies can be quite acceptable. Polysomnography may be done locally provided the facilities, proper equipment and interest exist. Currently, many medical centers are providing such comprehensive evaluations for patients with sleep disorders.

Treatment: In central sleep apnea, respiratory stimulants have reportedly had varying degrees of success. They include theophylline derivatives, naloxone, acetazolamide and the more widely used agents medroxyprogesterone acetate (Provera) 20 mg. sublingually every 8 hours or the anti-depressant clomipramine 75-125 mg. at night.

If the patient is obese, then an aggressive weight loss program should be undertaken. If the central hypoventilation is severe (e.g. Ondine's curse) or if conservative measures are ineffective, then a diaphragm pacer may be considered. It involves implantation of electrodes behind both phrenic nerves at the level of the midcervical spine. The electrodes are electrically stimulated via an impulse generator

that is surgically implanted in the chest wall much the same as a cardiac pacemaker. It in turn is driven by a radio-frequency generator carried by the patient. The phrenic nerves are electrically excited to cause the diaphragm to contract which results in inspiration. The respiratory rate is dialed-in on the radio transmitter. It has been performed on more than 200 patients worldwide and has been under development for the last 15 years. Alternatively, chronic ventilator and "iron lung" therapy have been the classical treatments for severe cases.

An enforced weight loss program also is mandatory in patients in whom the main apneic episode is obstructive and there is no definable lesion in the neck or upper airway. For unexplained reasons, the obstructive apnea and associated symptoms of daytime hypersomnolence, etc., may ameliorate with weight loss. If the oxygen desaturation encountered is extreme and/or if the patient's symptoms are severe, then a tracheostomy should definitely be considered. Complete bypass of the obstruction and total improvement in symptomatology is the rule following this procedure. Centrally acting respiratory stimulants may help to increase alertness but are of limited usefulness. Diaphragm pacing is of no value in obstructive-type apnea.

In mixed apnea the treatment is directed at the dominant event. If it is obstruction, successful treatment of that problem may leave a predominantly central apnea pattern. This usually tends to decrease over a period of several months provided the obstructive problem does not recur, and it may or may not require respiratory-stimulant measures. An interesting finding frequently made in patients with mainly central mixed apnea treated with diaphragm pacers is that a

previously unknown or "minor" obstructive defect is made worse, apparently because of increased respiratory effort. The patient then requires treatment for obstructive apnea, not uncommonly a tracheostomy. It is now thought that any obstructive element may be made worse with diaphragm pacing and that follow-up sleep recordings should be made in these patients to rule out obstructive apnea. It is not known if this same phenomenon is seen following treatment with respiratory stimulant drugs.

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Bilateral Calf Claudication Complicated by Hyperthyroidism

Introduction by Austin Gardner, M.D.: Today we meet to honor Dr. Goethe Link, in this his 100th year. His lifelong interest in thyroid disease stems from anatomical dissection of the thyroid gland initiated in the newly established Indiana University School of Medicine for which he was a prime mover. When he demonstrated his capability for tying the thyroid arteries, he embarked on a career of interests in thyroid disease that was consuming. He was a great student and teacher. The patient to be presented today came to St. Vincent Hospital just after Dr. Link's 100th birthday (May 20, 1979). Her clinical condition reminded me of his teaching. Dr. John Wiggans will present the case.

This paper is based on discussion during the Peripheral Vascular Conference conducted in October 1979 at St. Vincent Hospital, Indianapolis. Presentations are abstracted. This summary was prepared by Austin L. Gardner, M.D., Indianapolis.

The October 1979 Peripheral Vascular Conference was conducted in conjunction with the dedication of the Goethe Link Centenary Vascular Laboratory at St. Vincent Hospital.

Case Presentation by John Wiggans, M.D.: A 65-year-old white woman was admitted on June 4, 1979 with complaint of bilateral calf claudication and some rest pain in the left leg. Past history revealed right hemiplegia 11 years before with no residual. Review of systems revealed weight loss from 125 pounds to 60 pounds since 1968, increased appetite, nervousness, heat intolerance and frequent stools.

Physical examination revealed a thin, very alert, extremely nervous woman. Her blood pressure was 140/90 and her pulse rate was 140. She had bilateral carotid bruits and an enlarged right thyroid lobe. The heart beat was hyperdynamic, the chest was clear, the abdominal examination was negative. Femoral pulses were weak with no pulses below the femorals. There was marked elevation pallor and marked dependent rubor, but no ulceration. The impression was aortoiliac stenosis, bilateral carotid stenosis and question of hyperthyroidism.

The diagnosis of hyperthyroidism, confirmed by Dr. Daniel Boyd, was supported by an Iodine¹³¹ uptake of 67%, by an NTR of 1.23, and a T₄ of 18.8. On June 18, 1979 she was given six microcuries of Iodine¹³¹. Inderal 20 mg. QID was started. Doppler studies revealed ankle brachial ratio of .15 on the right side and .25 on the left.

Although severe arterial insufficiency was present, operative man-

agement awaited improvement of the thyroid condition. A brachial cephalic doppler study was normal.

She was discharged from the hospital and later developed an ischemic ulcer at the base of the right 5th toe. She was readmitted on Sept. 25, 1979, having gained 17 pounds. Thyroid studies were normal and she had a resting pulse of 80. An aortogram revealed a left iliac occlusion and stenosis of the right iliac artery and right superficial artery occlusion.

On Oct. 10, 1979 an aorto bifemoral bypass graft was carried out. Estimated blood loss was 1,500 cc. She required a large volume of fluid to maintain central venous pressure. The heart rate post-operatively was 150. After volume was replaced as manifested by central venous pressure rise, she was given Inderal and the pulse rate decreased to 100. Pneumothorax had resulted from subclavian catheterization and she required a chest tube.

Postoperatively, the doppler revealed ankle brachial at .4 on the right and .54 on the left. She had progressive healing of the ulcer. There was a two- to three-day period of mental obtundity, which cleared completely before release.

Discussion by Thomas Woerner, M.D.: When you add to the precarious problem of severe vascular disease with depleted tissue oxygen supplies and the marked increase

and need for oxygen in the face of hyperthyroidism, you are presented with a whole different set of not so pleasant problems. It is important to wait as long as is feasible to be sure that the euthyroid or normal thyroid state is achieved before an operation is safe.

Many times, even though the patient has been treated and is under good control, the stress of an operation will flare up the hyperthyroid state again.

I had the good fortune of spending time in the Thyroid Clinic with Dr. Link when I was a resident. I

learned a great deal about the clinical aspects of hyperthyroidism and hypothyroidism. I learned that to examine a patient's thyroid you placed him in a comfortable chair and stood behind to examine the gland. I learned that you can magnify tremors with pieces of

Goethe Link Centenary Vascular Laboratory--

The following is a summary of comments and activities that took place in October 1979 during the dedication of the Goethe Link Centenary Vascular Laboratory at St. Vincent Hospital, Indianapolis. Dr. Austin L. Gardner presided.

Dr. Link, who marked his 100th birthday May 20, 1979, earned his M.D. degree from the Central College of Physicians and Surgeons in 1902. He later became most famous as an anatomist, thyroid surgeon and astronomer. He is the only living graduate of an Indiana proprietary medical school and the only living member of the original faculty of the Indiana University School of Medicine.



PHOTO BY ED LACEY, JR.

Dedicated to Pursuit of Medical, Surgical Excellence

Presentation by Frank Ramsey, M.D.: Mrs. Link, ladies and gentlemen: Dr. Gardner and I represent many, many people on this occasion. Dr. Link, during a long and busy surgical practice, was loved and admired by thousands of physicians, nurses and nursing sisters with whom he worked. His dedication was emphasized by his teaching, by his skill as a surgical technician, by his intricate knowledge of anatomy and by his great love of nature. This has endeared him to all of us. His patients are also members of this great group. In retirement, he often encounters patients, some of whom he treated 30 and 40 years before, who speak to him in glowing terms of their gratitude for his skillful ministrations. Many thousands of other patients are equally grateful. This plaque to be presented is symbolic of the respect and admiration which we and other physicians, associates and patients are proud to proclaim. The Goethe Link Centenary Vascular Laboratory will be dedicated to the pursuit of excellence in medicine and surgery, a crusade to which Dr. Link had dedicated his happy and busy life.

paper placed on the outstretched hand. I saw and learned that the head on the chest gives a lot of valuable information about the thrust and pulsation of the heart, sometimes better than with your ear and your hand and the stethoscope. Dr. Link had a rating scale of five

items, the least and last of which were the laboratory data. He was very cautious and careful to see that the patients were euthyroid by his scale before he operated.

Discussion by Austin L. Gardner, M.D.: Dr. Link's practice of postponing operation until the patient

was absolutely ready for surgery resulted in his consecutive record of 2,043 thyroidectomies without a death. Before that he had done more than 20,000 thyroidectomies, starting in 1911.

At this time Dr. Frank Ramsey will make a presentation.

Mrs. Goethe Link accepted the plaque and presented it to Sister Clare Leaumont who represented Sister Theresa Peck, Administrator of St. Vincent Hospital.

Dr. Gardner introduced Frank K. Edmundson, Ph.D., chairman, Department of Astronomy, Indiana University.

Dr. Edmundson: It is a real honor and pleasure to be here today to participate in this honor to Dr. Link, and also to have Mrs. Link present and looking so well. My association with Dr. Link came as a result of his interest in astronomy. I first met Dr. Link during a visit to his observatory while it was still under construction, and while Harlow Shapley of Harvard University was here for a lecture to the Contemporary Club. Arrangements were made to have Professor Shapley see the observatory. Professor Cogshall, at that time chairman of the Astronomy Department at Indiana University, took me to see the observatory and to see Dr. Shapley. I rate Dr. Link as one of the two most remarkable individuals I have ever known. The other one is the astronomer, Henry Norris Russell, my wife's father. Both men had broad interests, interests outside their own particular professional fields. One of the things I have been astonished by and have admired over the years was Dr. Link's breadth of interest, not only in astronomy, but in many other areas as well.

There are approximately 80 Ph.D.s in astronomy who have their degrees as a direct consequence of Dr. Link's interest in astronomy and his gift of the Goethe Link Observatory to Indiana University. Many of these scholars are the chairmen of Astronomy Departments in universities all over the world. This is a monument to Dr. Link that will endure for a long, long time. I am very happy to have had the chance to say this here today.



Mrs. Link clasps the hand of Sr. Clare Leaumont, to whom she had just presented the dedication plaque.

Miss Dorothy White, president of the Indianapolis Chapter of the Audubon Society, made interesting comments concerning Dr. Link's knowledge and love of birds.

Malcolm Herring, M.D.: The Vascular Laboratory started with a nucleus of a Doppler Flow Velocity Machine of which you have seen some tracings this morning. This device determines whether flow is occurring in various blood vessels, arteries or veins, and is also capable of determining whether it is a high energy flow wave or a low energy one. The next advancement which is coming up soon will be the use of an imaging system whereby we use the Doppler effect to make an arteriogram without invasive maneuvers. We will be able to identify arteries accurately and obtain flow dynamic information.

CLINICAL NOTES

Proctology

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Hemorrhoidal Injections: Various Uses

Injection of internal hemorrhoids is usually associated in the public mind with ambulatory treatment. This is one use, but there are others. Among these uses are those of screening out innocent from malignant causes of bleeding, and determining whether the hemorrhoids play a part in vague symptoms arising in the anal, perianal, low back and urinary areas. Since the injections are readily available and should be relatively inexpensive, they can serve as an acceptable diagnostic tool.

That injections of internal hemorrhoids are so little used is a source of wonder to a proctologist. The technique can be demonstrated in half an hour. Interpretation of results will take longer but is not difficult. Materials and instruments are cheap and adequate. They consist of 5% phenol in sesame oil, a simple anoscope, a syringe with a collared needle, and cotton swabs. The collar should be about 3/8 of an inch from the tip of the needle. Although there may be some temporary discomfort, no significant complications have occurred.

Injections are made into extraluminal tissue. In fact, it is almost impossible to inject into an internal hemorrhoidal vein. The injections cause scarification and contraction of peri-venous and submucosal tissue and thus constrict hemorrhoids and alter tissue states.

At St. Mark's Hospital, the famous proctological hospital in London, injections are extensively used in treatment. This, alone, gives repute and authority to the use of injections in treatment and diagnosis, and disclaims the impression of some who associate injections with quackery. To anyone who has used

injections for various purposes, their value is unquestioned. Initial injections should be made well above the muco-cutaneous level, since some patients react more uncomfortably than others to the ensuing distension. The most redundant tissue is usually located at 3, 7, and 11 o'clock. The average quantity injected at each point is about 1 cc.

The most important diagnostic use of injections is in cases of rectal bleeding. Unfortunately, the patient's answers as to color, mixing with stool, and relationship to passage are fallacious. An elderly and wise physician reported to the office complaining of copious bright red stools. Simple anoscopic examination revealed tarry material which was found later to have come from a duodenal diverticulum. There had been oxidation of the dark blood in the stool when in contact with water in the commode.

Between history and coloproctoscopy there exists x-ray, sigmoidoscopy and injections as means of diagnosis. If not the best approach to differentiation between tumor and innocence, at least injection is as accurate and simpler. If bleeding does not stop after two or three injections, further investigation is indicated. Injections can be a valuable screening device in separating pathological from innocent bleeding in the years in which both are most numerous. Since the great majority of patients with bleeding have internal hemorrhoids as the source, much time and money can be saved by using injections diagnostically.

Diagnosis can be helped in an occasional case in which symptoms and physical findings are uninformative. These patients are apt to have been passed over by the physician because of their lack of symptoms suggesting a rectal focus. An

active lobbyist appeared in the office complaining of low back pain that was present when sitting or when driving a car. It was of such severity that he would leave the car after driving 30 or 40 miles and walk around for relief. He could entertain hunting parties and walk and be comfortable, but not fishing parties when he sat in a boat. There was no complain of pain, bleeding or prolapse, either with bowel movement or activity. Anoscopic and visual examination were negative for any abnormalities. He had consulted several doctors about his trouble, including an orthopedist who fitted him with a corset without benefit. After three submucosal injections, he was free of symptoms and was not seen again. I was unable to ascertain just why he suspected a possible rectal cause as the source of his trouble.

A very valuable use of injections is that of controlling or stopping known innocent bleeding. Such cases may be cared for adequately with injections. Many cannot be assured of their safety from cancer by pronouncements but may be, by stoppage of the bleeding, afforded psychological relief. One may wonder at times, when seeing the worst of these cases, if there has not been too much publicity of the danger of cancer of the bowel, particularly in view of the poor results of therapy. Injections are much more competent than suppositories. And fear is a disturbing disease.

SUMMARY

Injection of internal hemorrhoids and of perivenous rectal tissue can be of significant value in differential diagnosis in cases of vague or atypical rectal symptoms and rectal bleeding as well as mild therapy for itching, fullness and apprehension. Its ease of administration and safety suggests its frequent use. It can circumvent surgery in some cases. In a period of high medical costs, its low cost can be quite appealing. It can serve as a screening test where bleeding is the principal symptom. The shortcomings in this area are not greater than those of sigmoidoscopy.

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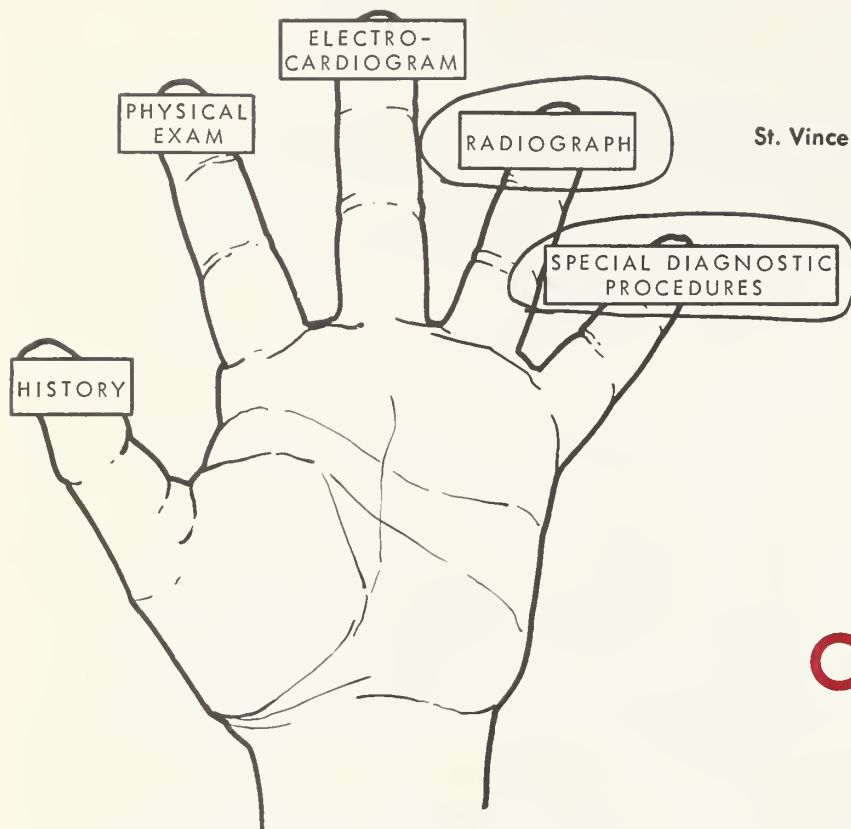
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THE FIVE FINGERS OF CARDIOLOGY

A 46-year-old man has experienced episodes of severe chest pain for five weeks. The pain is non-exertional, but awakens him each day, at approximately 5 a.m. The pain is characterized as an upper, mid-epigastric fullness that radiates retrosternally as a pressure sensation, and then radiates superiorly into the throat as a constricting sensation. Simultaneously, the patient experiences aching in his teeth, along with dyspnea and diaphoresis. Each episode of pain lasts approximately five minutes. The pain is increasing in frequency, and five severe episodes have occurred over the week prior to his evaluation. The patient has

learned that the chest pain resolves quickly in response to sublingual nitroglycerin.

During this same period of time, the patient's activity is limited not at all. For instance, he even played 32 games of tournament tennis in one day, with no chest discomfort.

The cardiac physical examination is normal except for paradoxical splitting of the second heart sound. The electrocardiogram demonstrates left bundle branch block.

The treadmill exercise test is negative. The patient achieves the desired heart rate without any symptoms; the left bundle branch block pattern does not change.

A frame of the cineangiogram of the right coronary artery is illustrated. The left ventriculogram and the left coronary artery were completely normal.

The Five-Finger Approach to Cardiac Diagnosis was conceived by W. Proctor Harvey, M.D., of Georgetown University, and further developed by J. Willis Hurst, M.D., of Emory University into its present form: The integration of all five approaches is diagrammed into a "fist" of cardiac diagnosis.

Periodically, THE JOURNAL will present a "finger of cardiology" as a self-assessment, emphasizing current and innovative diagnostic and therapeutic principles.

QUESTIONS

- What is the explanation for the patient's non-exertional chest pain?
- Interpret the right coronary angiogram.
- How might your diagnosis be definitively established?
- What therapy is available to prevent a recurrence of the chest pain?

A Self-Assessment

ANSWERS

The patient's description of the chest pain is characteristic of angina pectoris, except that it occurs at rest rather than with exertion. The cyclic nature of the pain (i.e., its appearance at about the same time each morning, when the patient is asleep) suggests that the angina is Prinzmetal's Variant Angina. With a negative stress test, the probability is that transient coronary spasm reduces myocardial oxygenation to result in the angina pectoris.

The right coronary angiogram demonstrates mild, diffuse narrowing of the right coronary artery; however, the degree of narrowing is insufficient to reduce coronary blood supply, and, hence, should not result in angina pectoris. Only if the lumen were significantly reduced by spasm should this symptom develop.

Several provocative tests have been developed for inducing coronary spasm at the time of coronary cineangiography, thereby proving the diagnosis of coronary spasm. Ergonovine is the agent most frequently administered, although parasympathomimetic agents, such as methacholine, cold pressor tests, and catecholamines along with beta blockade (to leave alpha adenergetic vasoconstriction unopposed) may all provoke the same degree of spasm.

In response to intravenous Ergonovine, the right coronary artery was totally occluded by spasm. See Figure 2. Simultaneously, the patient developed his characteristic chest pain. Transiently, the left bundle branch block pattern resolved, to demonstrate marked ST-segment elevation in Leads 2, 3 and AvF, which record the elec-

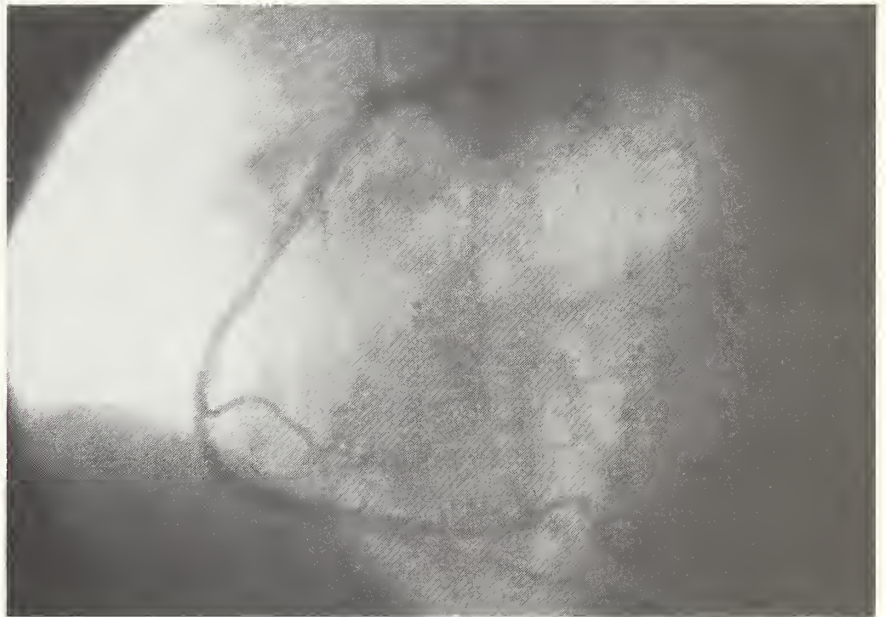


FIGURE 1
Right coronary angiogram

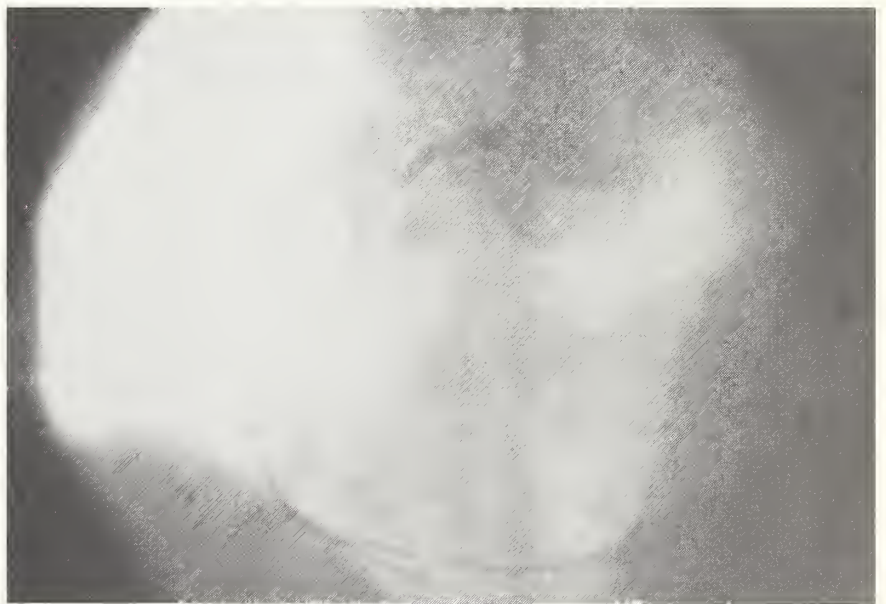


FIGURE 2
Right coronary angiogram after "provocation"

trical activity over the inferior wall of the heart, which receives its blood supply by the transiently occluded right coronary artery.

Nitroglycerin will generally relieve the coronary spasm once it has

developed. This patient received immediate relief by nitroglycerin, and the right coronary artery dilated back to its previous size.

Longacting nitrates are often ef-

CONTINUED ON PAGE 35

ASBESTOS:

A Ubiquitous Fibrogenic and Oncogenic Dust

ERIC L. DYER, M.D.
Bedford

ASBESTOS is a collective term for six naturally occurring, complex silicates of magnesium, iron and calcium. Asbestos is fibrous, flexible, easily woven, heat resistant, nonconductive, acid-stable and practically indestructible. Because of these properties it has more than 3,000 industrial applications. More than a million tons of asbestos are imported annually into the United States, and the rate is increasing.

A clear association has been noted between asbestos exposure and lung fibrosis,¹ primary lung cancer,² pleural and peritoneal mesothelioma,^{3,4} and several gastrointestinal malignancies.⁵

The British in 1933 were the first to legally address the disease potential of asbestos by establishing standards of exposure in industry. Most asbestos used in the United States is the chrysotile type ("white asbestos"), imported from Quebec, the world's main supplier. All types of asbestos are oncogenic, but the crocidolite type ("blue asbestos"), mined in Australia, South Africa and Bolivia, is the most oncogenic.⁶

Asbestos is ubiquitous. Many

items common to our industrialized environment may contain asbestos: pipe and wall insulation, acoustical paneling, cement, plaster, curtains, floor tile, rubber, electrical wiring, putty, clipboards, writing paper, filter paper, cardboard and artificial wood paneling. The clutch facings, brake linings, gaskets and undercoating of our automobiles may contain asbestos.⁷ The significance of exposure to these or other common asbestos-containing products is unknown. Twenty to 100% of urban dwellers have "ferruginous bodies" (morphologically distinct particles usually composed of an asbestos fiber coated with protein and iron) in their lungs at autopsy. However, no relation exists between prevalence of ferruginous bodies and pulmonary fibrosis or cancer.⁸

The person with definite increased risk of developing an asbestos-related disease is anyone who is or has been directly involved in the production, processing, handling or using of asbestos. High risk occupations include workers in the asbestos insulation, asbestos textile, asbestos cement and shipbuilding industries and asbestos miners or millers.

But a secretary in a shipbuilding yard, a resident along a road where asbestos is trucked, the launderer of an asbestos miner's clothing or a

demolition worker at an old building containing asbestos materials also carry increased risk. About 5 million U.S. citizens have been exposed to asbestos in shipyards alone.⁹

The current federal standard (permitting 5 fibers per ml of air) regulating asbestos exposure among industrial workers may need revision as long-term data accumulate. The history of many occupational diseases reflects initial injustice to workers because of ignorance about the pathogenicity of environmental materials.

Asbestos-related morbidity and mortality are increasing in this country.¹⁰ At least two factors may account for this increase. First, more people are being exposed to asbestos. Second, a latent period of many years elapses between asbestos exposure and appearance of disease. Persons exposed decades ago only now may be entering the period when disease becomes manifest. The median latent period is 20-25 years for bronchogenic carcinoma,^{11,12} about 30 years for mesothelioma,¹³⁻¹⁴ and 20-40 years for gastrointestinal cancers (esophagus, stomach, colon-rectum).⁵ Pleural mesothelioma and adenocarcinoma of the lung are the malignancies most commonly associated with asbestos exposure.¹⁰

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Cigarette smoking and asbestos exposure is a particularly oncogenic combination. Selikoff, in a study of asbestos insulation workers in New York City, found that cigarette smoking alone increased the risk of bronchogenic carcinoma 11 times controls. But asbestos exposure and cigarette smoking together increased the risk 92 times.¹⁵

Occupational exposure to asbestos increases a person's risk of pleural or peritoneal mesothelioma about 300 times.¹² About 70% of persons with mesothelioma have had known exposure to asbestos, but only about half of these persons have had occupational exposure.¹³ While most asbestos-related lung cancers are associated with pulmonary fibrosis, most pleural mesotheliomas are not.^{16,17} The risk of lung cancer among asbestos workers is 6 to 10 times the expected rate.¹¹ Mortality rate from asbestosis and asbestos-related neoplasia correlates directly with duration and magnitude of exposure, but exposure as short as one month has been related to later development of mesothelioma.¹⁸

It is obviously important for physicians to identify by careful history those patients with significant (greater than one month) occupa-

tional exposure to asbestos. Many Hoosiers were exposed during World War II shipbuilding. Those persons, especially, need to stop smoking or never start. Pleural effusions and plaques, diffuse pleural thickening, interstitial fibrosis or

mass lesions should not escape early detection in this population. While remaining realistic about the oncogenic potential of asbestos, the physician can reassure the patient that most persons exposed to asbestos never suffer ill effect.

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THE FIVE FINGERS

CONTINUED FROM PAGE 33

ficacious in preventing a recurrence of Prinzmetal's Variant Angina. Dipyridamole (Persantine) is another possible therapeutic agent. This patient was intolerant of these preparations.

An entirely new class of agents, as yet experimental, is being investigated as anti-anginal agents. These calcium antagonists, by preventing the flux of calcium into the smooth muscle of the coronary artery, prevent coronary spasm. This patient received one such agent, Nifedipine, with an excel-

lent clinical response. He has not experienced recurrence of angina, and he remains asymptomatic.

The prognosis of patients with Prinzmetal's Variant Angina is quite variable. Some patients are at exceptionally high risk, since they developed transient heart block, or lethal ventricular tachycardia-fibrillation during the ischemic episodes. Myocardial infarction can also result from more sustained coronary spasm. Presumably, the calcium antagonists will improve the prognosis remarkably.

Brain Stem Audiometry

BSER, a new, non-invasive way to examine the human auditory system, is a clinically valuable diagnostic tool. It is an objective test requiring little or no patient cooperation....

ROBERT G. CHAPLIN, M.A.
LAVERNE B. TUBERGEN, M.D.
Indianapolis

ARECENTLY DEVELOPED technique termed "brain stem audiometry," or "brain stem electric response" (BSER) audiometry, provides a new way of examining the human auditory system.

Brain stem audiometry is now giving valuable information about the hearing capabilities in patients who are difficult to test, such as infants. With BSER it also is possible to differentiate the site of lesions in the auditory pathways, and BSER may be the most sensitive test for acoustic neuroma. A major advantage of BSER lies in the non-invasiveness of the technique.

Human brain electrical potentials were first reported in 1929. In 1939 Davis¹ reported that auditory stimulation caused recognizable changes in human brain wave activity as recorded on electroencephalograms (EEG). Interest lagged in studying the effects of auditory stimulation on the EEG until the mid-1950s when the principles of averaging techniques were introduced to neurophysiology. The introduction of the averaging computer led to a resurgence of interest in auditory-evoked potentials.

More recently, with the growth of electronic and computer technology, a wealth of data concerning evoked potentials of auditory origin has appeared. Once only a subject for laboratory research, the study of auditory-evoked potentials has led to the development of brain stem electric response (BSER) audiometry, now a clinically valuable diagnostic tool.

A large number of different components of the auditory-evoked potential can now be recorded from the human scalp. The earliest of potentials evoked by a click or tone burst appears about one millisecond after the onset of the stimulus, while the last appears several hundred milliseconds later. The potentials having latencies greater than 10 milliseconds are relatively large and have been studied for some years by use of scalp electrodes. The potentials appearing in the first 10 milliseconds are relatively small and were reported by Jewett and Williston in 1971.⁴

Since the late 1960s a procedure termed "electrocochleography" has been used to measure the initial potential occurring in the first few milliseconds after an abrupt auditory stimulus. Electrocochleography uses an electrode placed as close to the cochlea as possible. The electrode is either inserted through the tympanic membrane on the promontory of the middle ear or is placed in the external ear canal near

to or in contact with the tympanic membrane.

This technique has provided a reliable and sensitive measure of the cochlear and eighth nerve electrical activity resulting from a click or tone burst stimulus. The technique has the disadvantage of being an invasive procedure that usually requires the insertion of an electrode through the tympanic membrane, though no complications have been reported in a large series of cases.

Jewett and Williston in 1971 reported recordings of additional early potentials or waves that can be measured from the scalp with appropriate instrumentation. The early waves, occurring in the first 10 milliseconds after auditory stimulation, apparently reflect the activation of the auditory nerve and the brain stem auditory tracts and nuclei. (See illustration)

The distance between peaks indicates the time for the nerve impulses to travel from one generator site to the next. The first wave, the same one measured in electrocochleography, is primarily a response from the combined nerve fibers in the cochlea and the eighth nerve. Waves two through five, recorded in the first 5 to 8 milliseconds after application of the stimulus, seem to be generated from successively higher levels of the brain stem. Later waves probably arise from the subcortical and cortical areas.

From the Department of Otolaryngology, Indiana University School of Medicine, Indianapolis, Ind.

The study of the evoked potentials observed in the first 10 milliseconds after auditory stimulation has been termed "brain stem electric response" (BSER) audiometry, or simply "brain stem audiometry," because these events are apparently originating in the brain stem portion of the auditory neurologic pathways.

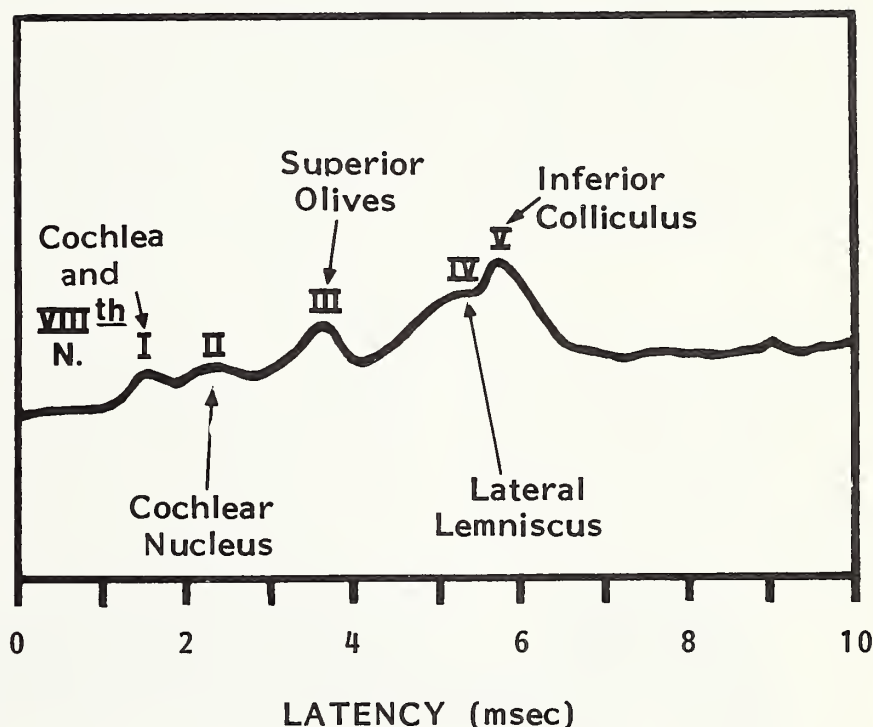
Brain stem electric response audiometry, with its measure of the first five potentials or waves and representing responses from cochlea through brain stem, is felt to have an advantage over electrocochleography, which measures only the first wave, that from the cochlea and the eighth nerve. An additional advantage of BSER over electrocochleography is that BSER is a non-invasive procedure using surface electrodes.

BSER appears also to have some advantages over other EEG measures of the late evoked potentials of more central origin. The BSER results emanate from the lower brain stem levels of the auditory system, and are not affected significantly by sedation or sleep states, both of which do affect the relatively late EEG measures of probable cortical origin.

The clinical applications of BSER (and electrocochleography) fall into two basic areas: 1) Detection and quantification of hearing, and 2) Localization and monitoring the progress of neurological pathology.

There is need for a technique to evaluate the peripheral hearing function in certain clinical cases where conventional behavioral audiometry is impossible or unreliable, such as in very young children, the mentally retarded, and cases of functional hearing loss. BSER has proven of value in the evaluation of these cases because it is an objective test requiring little or no patient cooperation. A reliable esti-

BRAIN STEM ELECTRICAL RESPONSE Normal Adult - 80 dB SL Click Stimulus



mate of the actual hearing level can be made by determining the lowest intensity level at which these potentials can be identified.

Brain stem electric response may often be helpful in other clinical applications, especially the determination of the site of neuropathologic deficits and the monitoring of pathological changes. The one measurement of brain stem responses that has become the most valuable in this regard is response latency, that is, the time interval between the application of an auditory stimulus and the onset of a particular electrical response.

Earlier electrocochleography studies focused on the latency of the first potential. With the development of BSER and its recording of the later brain stem responses, more attention has been given to latency measures of these later potentials.

Presently most attention is given to latency studies of the fifth potential or wave because of its size and ease of detectability. By simply measuring the latency of the fifth wave for successively greater intensities of a click stimulus, it is possible to differentiate among normal hearing, middle ear pathology, cochlear pathology, and retro-cochlear involvement.

BSER shows promise in providing the capability to detect retro-cochlear lesions, and acoustic tumors in particular. It has been observed that compression on the eighth nerve by a tumor will usually produce a delay in the brain stem responses, even in cases in which the hearing may appear to be audiometrically normal. In one recent study of 200 patients with surgically confirmed acoustic tumors, it was reported that 98% had abnormal

latencies of the brain stem electric responses.

Neurologists also have shown an interest in this tool because it gives them a means of evaluating the activity of subcortical centers, which heretofore has been difficult to study. BSER provides a means of detecting and monitoring various brain stem pathologies such as tumors, demyelinating diseases, aneurysms, and "brain death."

SUMMARY

Brain stem electrical response is the latest addition to the battery of hearing tests available for clinical use. It does not replace conventional audiometry. It is the only measure of electrical activity of the peripheral and central auditory nerve pathways. It is an "objective" test as far as patient response is

concerned, but it is not an "objective" test in the interpretation of the results. There is some risk in interpreting BSER results in isolation.

For the maximum value to be obtained from BSER it must be used in conjunction with history, the otologic examination and clinical observation, with audiometry, and with impedance and acoustic reflex measures. It must be carefully interpreted by a professional who is familiar with these procedures.

Despite these limitations and cautions, an increasing number of otologists, audiologists, and neurologists are now using BSER measures and finding them to be of considerable clinical value. From what has been learned of these measures in a relatively short time, one can-

not help but be enthusiastic about future applications. This technique now permits direct examination of the human auditory system in a way that previously was not possible.

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NOTES FROM DOWN UNDER



DOUGLAS F. JOHNSTONE, MD
Indianapolis

Plasmapheresis

Circulating immune complexes are involved in the pathogenesis of several disease states for which plasmapheresis has shown to have a favorable therapeutic effect. Diffuse vascular injury secondary to deposition of soluble immune complexes may be involved in the etiology of thrombotic thrombocytopenic purpura.

Large volume plasma exchanges via a continuous-flow cell separator were performed in five patients with this disease. Three of these patients showed dramatic laboratory and clinical improvement. Concomitant drug therapy including immunosuppressives and platelet inhibitors is discussed. The importance of early diagnosis and therapy before the development of irreversible organ damage is stressed.

Since plasma exchange may offer a chance for significant decrease in morbidity and mortality, its use should be considered in patients with this disorder.

Coronary Risk Factor Screening

Ten thousand self-referred subjects were screened for known coronary risk factors over a year period. 10.4% of males and 4.9% of females had at least two of the risk factors of hypertension, cigarette smoking and hyperlipidemia. Follow-up of 354 patients receiving treatment as a result of the original screening was evaluated eight and 15 months later and a significant fall in blood pressure, plasma cholesterol and body weight noted.

The voluntary nature of such a study may select a patient population more willing to comply with subsequent treatment but nevertheless demonstrates ability to favorably intervene in the modification of such risk factors. A leveling off and decline in cardiovascular deaths during recent years may reflect in part such intervention.

Methadone Blockade

A series of patients involved in a prolonged Methadone maintenance program were followed closely in an effort to monitor not only adherence to Methadone use but also return to abuse of other drugs, employment, criminal activity, general physical and psychiatric health and other parameters of social rehabilitation.

Approximately two-thirds of the patients maintained

three years of Methadone blockade and a similar number remained free of criminal activity. Seventy-two per cent of patients were reunited with their family, fully employed most of the time and judged to be leading a "happy and productive life."

Such successful rehabilitation is better than that reported in other Western countries, including the United States. Various reasons are cited, including the methods of administering such programs.

Maternal Alcoholism

The use of alcohol by adolescent and young females is increasing dramatically in Western society. Six children affected by the fetal alcohol syndrome are discussed through a prolonged follow-up period.

All six children had prenatal and postnatal growth retardation, and gave a history of difficulty in feeding at some point. Facial features included narrow forehead, hypertelorism, short upturned nose and low bridge, micrognathia and large simple ears. Birth weight was small and catch-up growth failed to occur, supporting the suggestion by some that Ethanol or its metabolic products reduces the number of embryonic cell divisions, thereby limiting growth and development potential.

The particular vulnerability of the first trimester fetus and the potential for adverse effects from binge drinking as well as regular heavy drinking is discussed. More work on concomitant variables such as nutritional state of the mother and use of drugs and other potential toxic substances is necessary. The importance of both the immediate and long term effects of the fetal alcohol syndrome is heightened by increasing Ethanol use among women of child bearing age in our society.

For the present, it would seem prudent to advise women to curtail their alcohol consumption to no more than one ounce of absolute alcohol per day or less prior to and during pregnancy.

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Hoosier Physician Fees Lower Than National Average Figures

Last fall, Blue Cross of Indiana released a study that revealed an average day in the hospital will cost a patient comparatively more in 40 other states and the District of Columbia than it will in Indiana.

In fact, Blue Cross of Indiana said its study credited Indiana with being the 10th lowest state in the nation when comparing per capita income with hospital costs. The national average was \$173.98 per day; Indiana's adjusted average daily charge was \$151.17. The state's hospital rate setting system was credited with holding the lid on soaring costs.

Now comes a report from Blue Shield of Indiana and it, too, seems to prove that efforts by the private sector can be as effective, or even more so, than state or federally mandated programs.

Blue Shield, the Medicare Part B Carrier for the state, reports that Hoosier doctors have a pattern of charging their Medicare patients anywhere from 10% to 30% less for medical services than the national average charge for the same services.

The findings were based on a comparative study that matched an average of Medicare Prevailing Charges in Indiana against national average figures developed by the Health Care Financing Administration (HCFA) of DHEW.

The study compared the average prevailing charge by physicians in Indiana for 11 services with the national average charge for the same services. It was found that Indiana doctors were charging less than the national average for all 11 services.

PREVAILING CHARGE COMPARISON

1979-Indiana and National Average Figures

	Indiana	United States	Indiana Percentage of U.S.
Initial Limited Office Visit	\$ 18.51	\$ 27.62	67%
Routine Hospital Visit	10.95	15.56	70%
Radical Mastectomy	604.03	750.01	80%
Insert Pacemaker	675.00	782.04	86%
Appendectomy	297.10	390.67	76%
Hernia Repair	308.96	384.03	80%
Hysterectomy	617.93	716.65	86%
Cataract Operation	625.50	700.79	89%
Complete Blood Count	8.00	9.46	84%
Cholesterol Lab Test	6.33	7.41	85%
Blood Sugar Lab Test	5.66	6.64	85%

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Indications: For the treatment of mild to moderately severe pneumococcal respiratory tract infections and mild staphylococcal skin and soft-tissue infections that are sensitive to penicillin G. See the package literature for other indications.

Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies

before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

[102175]

***Equivalent to penicillin V.**

Additional information available to the profession on request.



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Child Care Conference

The 15th Annual Indiana Multidisciplinary Child Care Conference will be held May 21-22 at the Marriott Inn, Indianapolis.

Pediatric infectious disease, behavioral pediatrics, pediatric dermatology, adolescent medicine, developmental function, and pediatric neurology will each be presented in seminar form.

For information, write Morris Green, M.D., 1100 W. Michigan St., Indianapolis 46223.

Breast Cancer Seminar

"Treatment of Breast Carcinoma" is the subject of an afternoon seminar scheduled by St. Mary's Medical Center, Evansville, for Thursday, Feb. 21.

The seminar will begin at 1 p.m. and continue until 4:30. Dr. Max Kremzar will serve as moderator.

The program is accredited for Category 1 prescribed hours, by the AAFP, and cognates by ACOG. For further information, contact W. Thomas Spain, M.D., St. Mary's Medical Center, 3700 Washington Ave., Evansville, Ind. 47750. Tel: (812) 479-4000.

Rheumatic Diseases Course

Selected Aspects in Rheumatic Diseases" will be the subject of a two-day CME course to be conducted April 17-18 by the University of Louisville School of Medicine.

The registration fee is \$95 for physicians and \$65 for other health professionals. The course is accredited for 11 Category 1 hours by the AMA and for 11 prescribed hours by the AAFP.

For details write the university at P.O. Box 35260, Louisville 40232.

Graduate Medical Assembly

The 43rd Annual New Orleans Graduate Medical Assembly will be held Feb. 27 through March 2 at the Fairmount Hotel in New Orleans.

Preliminary program is available on request to Tulane Medical Center, Room 1538, 1430 Tulane Ave., New Orleans, La. 70112.

Emergency Medicine Ski Confab

The Mammoth Mountain Emergency Medicine Ski Conference, with 24 hours Category 1 AMA and American College of Emergency Physicians credit and 24 hours elective credit for AAFP, will be held at Mammoth Lakes, Calif., March 9-15. The fee is \$250.

Write Daniel L. Abbott, M.D., P.O. Box 52-B, Newport Beach, Calif. 92662, or phone (714) 642-7080.

Polytomography of the Temporal Bone

The 22nd two-day symposium on Polytomography of the Temporal Bone will be given under the auspices of the Wright Institute of Otology at Community Hospital, Indianapolis, April 19-20. Participation meets the criteria for 12 AMA Category 1 credit hours. Fee for the course is \$300.

Subjects include "Basic Anatomy of the Temporal Bone" and "Technique of Polytomography of the Temporal Bone" with demonstrations of normal tomograms. Pathological conditions revealed by polytomography will be shown on original tomograms and the clinical applications will be discussed.

Contact The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis 46219. Tel: (317) 353-5679.

Sports Medicine Course

The Center for Sports Medicine of Northwestern University Medical School, in conjunction with the North Carolina Department of Public Instruction, will sponsor a postgraduate course in Sports Medicine at the Intercontinental Hotel, Maui, Hawaii, March 9-16. Twenty five hours of CME Category 1 credit will be awarded.

For information, write Marianne Porter, Center for Sports Medicine, 2-063, 303 E. Chicago Ave., Chicago 60611.

Johns Hopkins Course

"The Pediatric Approach to Common Neurological Problems" is the subject of a postgraduate course to be conducted Feb. 24-26 at The Johns Hopkins Medical Institutions. The course carries 22 AMA Category 1 credit hours. The fee is \$225.

For further information, write Johns Hopkins University, 720 Rutland Ave., Rm. 22, Turner Aud., Baltimore, Md. 21205.

Hyperbaric Oxygen Conference

The 5th annual conference on Clinical Application of Hyperbaric Oxygen is scheduled for June 11-13 at the Memorial Hospital Medical Center of Long Beach, University of California, Irvine Center for Health Education.

The clinically oriented conference will address the currently accepted uses of hyperbaric oxygen in plenary sessions and will include original papers, workshops, sound slides and scientific exhibits.

For information, contact G. B. Hart, M.D., Director, Baromedical Dept., Memorial Hospital Medical Center, 2801 Atlantic Ave., Long Beach, Calif. 90801.

Medical Self-Assessment Program

A review course for the American College of Physicians' Medical Knowledge Self-Assessment Program V (MKSAP V) will be held March 22-23 at the Sheraton West Hotel, in Indianapolis.

MKSAP V is a comprehensive program for updating a physician's knowledge in internal medicine. The course will deal with hematology, cardiovascular diseases, pulmonary diseases and nephrology. A physician who enrolls in MKSAP V receives a sequence of materials for home study and may attend special review courses in various locations. The course director is Richard Dexter, M.D., professor of medicine, I.U. School of Medicine. Fees for the course are as follows: Fellows, residents and research fellows, \$100. ACP Associates, \$50. Non-members, \$150.

'Abdominal Imaging' Course

"Abdominal Imaging" is the subject of the annual postgraduate course in radiology offered by Duke University Medical Center. It will be conducted May 5-9.

The course is accredited for 30 CME hours. Registration fee is \$300, or \$150 for those in training if accompanied by a letter from department chairman.

Write Robert McClelland, M.D., Radiology-Box 3808, Duke University Medical Center, Durham, N.C. 27710.

CME in the Caribbean

"Infectious Diseases Today" is the subject of a CME course to be conducted Feb. 9-16 by Wayne State University School of Medicine on a Caribbean cruise ship, the TSS Festivale. Credit for 36 prescribed hours with AAFP and 36 hours Category I will be given.

For information write Division of Continuing Medical Education, 1206 Scott Hall, Detroit, Mich. 48201, or call (313) 577-1180.

3-Day Seminar in Nassau

A three-day seminar, "Rational Behavior Therapy in Clinical Practice," will be conducted March 7-9 in Nassau, Bahamas.

The seminar is sponsored by the Rational Behavior Therapy Center at the University of Kentucky College of Medicine. It will cover the use of RBT techniques in treating emotional and behavioral problems such as depression, anxiety, anger, alcoholism, compulsive overeating and many others. Seminar leaders will include Maxie C. Maultsby, M.D., Timothy McCartney, Ph.D., and William E. Simon, Ph.D.

The fee is \$150. The seminar is certified for 20 AMA Category 1 credit hours.

For accommodations, contact the Bahamas Family Institute, P.O. Box SS 6363, Nassau, Bahamas, tel: (809) 32 32459. For additional information, contact Barbara Hood, RBT Center, 678 Allwyn St., Baldwin, N.Y. 11510, tel: (516) 546-6646.

Critical Care Symposium

The Caylor-Nickel Hospital will conduct a Critical Care Symposium Feb. 9-10 at Potawatomi Inn in Pokagon State Park, Angola. It is certified for eight hours of Category 1 credit with the AMA and the AAFP.

Speakers will include Ramalingam Balamohan, M.D., cardiologist at Caylor-Nickel Clinic; Robert A. Klocke, M.D., chief, Pulmonary Disease, State University of New York at Buffalo; Richard N. Hatzen, M.D., director, Pulmonary Function Lab, Caylor-Nickel Clinic; and R. Joe Noble, M.D., cardiologist, St. Vincent Hospital, Indianapolis.

For details, including cost, write to Mrs. Jane Thompson, Caylor-Nickel Hospital, 309 S. Main St., Bluffton, Ind. 46714.



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A foundation for charitable, educational, and scientific purposes, organized by the ISMA as an endowment fund to support the educational mission of the Association and THE JOURNAL.

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The Foundation is managed by a board of directors that comprises the members of the ISMS Executive Committee. At present, proceeds from the Foundation investments are awarded to THE JOURNAL to further the continuing medical education program.

Memorial contributions made to the Foundation in lieu of flowers will be acknowledged by the secretary in a letter to the family of the deceased.

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literary or educational purposes"*

Sleep Apnea Syndromes

CONTINUED FROM PAGES 21-26

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223.**

True-False:

1. Most patients with sleep apnea syndromes have a sleep complaint of some type.
2. The incidence and prevalence of the sleep apnea syndromes are not known.
3. These disorders rarely occur in thin persons.
4. Patients typically have hundreds of episodes each night for several years.
5. Patients with Ondine's curse, idiopathic hypoventilation, characteristically present at ages 40-60 and they often have experienced near-sudden-death as infants.

Answers to the CME quiz that appeared in the December 1979 issue of THE JOURNAL with Part 3, Secondary Somatic Problems, by David F. Wehlage, M.D.

- | | |
|------|------|
| 1. c | 4. a |
| 2. a | 5. c |
| 3. d | 6. d |

Answers to the CME quiz that appeared in the December 1979 issue of THE JOURNAL: "Laboratory Aids to Psychiatric Practice," by Stephen R. Dunlop, M.D.

- | | |
|------|-------|
| 1. a | 6. d |
| 2. d | 7. a |
| 3. a | 8. a |
| 4. a | 9. d |
| 5. d | 10. b |

Multiple Choice—Choose the one best answer:

6. The most common type of sleep-apneic episode is:
 - a. Central
 - b. Obstructive
 - c. Central-Obstructive (Mixed)
 - d. Obstructive-Central (Mixed)
7. Sleep recordings in these patients (polysomnography) usually reveal:
 - a. Only one type of apneic episode
 - b. No helpful information
 - c. All three types, with one type predominant
 - d. Narcolepsy
8. The following are associated with obstructive sleep apnea, EXCEPT:
 - a. Adenotonsillar hypertrophy
 - b. Micrognathia
 - c. Brainstem infarction
 - d. Goiter
9. The following are treatments for central-type sleep apnea, EXCEPT:
 - a. Tracheostomy
 - b. Weight loss
 - c. Respiratory stimulants (Provera, clomipramine, theophylline, etc.)
 - d. Diaphragm pacer
10. A middle-aged male with complaints of excessive sleepiness whose wife relates that he frequently stops breathing during sleep and snores so loudly that everyone's sleep is disrupted, most likely has:
 - a. Narcolepsy
 - b. Mixed-type apnea
 - c. Central apnea only
 - d. No detectable disorder

Answer sheet for Quiz: (Sleep Apnea . . .)

- | | |
|---------------|-------------|
| 1. True False | 6. a b c d |
| 2. True False | 7. a b c d |
| 3. True False | 8. a b c d |
| 4. True False | 9. a b c d |
| 5. True False | 10. a b c d |

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this month's quiz, send your completed, signed application before Feb. 10, 1980, to the address appearing at the top of this page.



AUXILIARY REPORT

Charlotte (Mrs. Abner P.) Bennett
President, ISMA Auxiliary

This month's Auxiliary Report was prepared by Vivian (Mrs. Marvin E.) Priddy of Fort Wayne, AMA-ERF treasurer.

A great deal of pride is always felt by the Auxiliary when it feels that its efforts have served the purposes of ISMA. We like to feel that when called upon we have been able to assist in any or all efforts requested. Because medical legislation is one area of mutual and vital concern to both our organizations, we try very hard to be as effective as possible.

During late summer, it became evident that perhaps we needed to change our approach to influencing the public and the legislators. The luncheon for the legislators that seemed very effective in the beginning has become increasingly hard for the legislators to attend. It also has been difficult for auxiliaries to promote. A cocktail party during the early evening hours was better timing for the legislators but virtual-

ly impossible for M.D. wives and mothers.

Questionnaires were sent to all legislative chairpeople and county presidents asking for evaluation and recommendations for future legislative endeavors. The tabulation indicated that we need to be better educated concerning the issues, to concentrate on regional effectiveness, and to foster better face-to-face contact with local legislators.

To implement these goals, we hope to arrange three regional workshops for all interested auxiliaries, county presidents and legislative chairpersons. Our national regional legislative representative, Ruth Dixon, has supported the regional workshop concept and hopes to attend, but we rely most heavily on the ISMA staff for our direction and instruction in this area. We hope that

the workshops will spawn meetings with legislators in each area.

The AMA key contact program has been extended to include Auxiliary members. Because we have no field representative in our organization as you do, we are obliged to rely on the U.S. Postal Service, a much less effective means of communication than personal contact. By the end of the year we hope to have added a key contact auxiliary for each M.D. key contact. Meanwhile, the best we can do is to supply county legislative chairpersons to fill the gap, and not every county has a legislative committee.

We thank the ISMA for the support given us in the past—financially, the expertise of staff, and mostly the confidence extended our organization in being asked to carry out your purposes.

There's a Word for It **Crohn's Disease**

RICHARD J. NOVEROSKE, M.D.
Evansville

At an international meeting of gastro-enterologists over 10 years ago, it was recommended that the eponym, *Crohn's Disease*, be used instead of *regional enteritis* or *regional ileitis*, etc., for the edematous and granulomatous inflammatory disease of unknown cause that can affect any part of the gastro-intestinal tract.

We usually like to steer clear of eponyms and use a more descriptive term, but in the case of *Crohn's Disease*, the eponym seems better.

Crohn's Disease is not limited to the ileum or the intestine; it can involve the colon, and it rarely has involved the stomach and esophagus.

And it isn't necessarily located in one region in one patient; it can involve different segments of the intestine at the same time.

Some have suggested using *mucosal* and *trans-mural* colitis to differentiate between *Crohn's Disease* and idiopathic ulcerative colitis involving the colon. But this set of terms breaks down in practice too, for perforation of the intestinal wall (a trans-mural disease) can occur with either disease.

I think *Crohn's Disease* is the best term at this time. But what do you think?

\$1 Million From PMA Foundation Supporting 52 Researchers Nationwide

Fifty-two scientists in universities throughout the nation are presently furthering the causes of research and progressing in their own careers through support from the Pharmaceutical Manufacturers Association Foundation.

The PMAF grants, totaling more than \$1 million in 1979, aid student and faculty scientists for one, two or sometimes three years according to their ability, need and the vitality of their research. Funds are dispensed through eight programs based on scientific discipline and career level.

The foundation awarded a single grant of \$50,000 last year to the clinical pharmacology section of the Louisiana State University Medical Center under the direction of John T. Wilson, M.D. The one-year grant is designed specifically for new clinical pharmacology units or those with new directors.

Other PMAF awards programs are:

- Faculty Development Awards in Clinical Pharmacology. Began in 1967. Four recipients in 1979. Program designed to provide salary and benefit support for junior faculty members.

- Faculty Development Awards in Basic Pharmacology. Began in 1973. Three recipients in 1979. Program designed to maintain academic capability in basic pharmacology and ultimately expand the faculty base.

- Fellowships for Careers in Clinical Pharmacology. Began in 1973. Two recipients in 1979. Program designed to support clinicians for

one or two years of intensive study in any of the basic sciences of pharmacology.

- Research Starter Grants. Began in 1972. Twenty-four recipients in 1979, each receiving grants of \$6,000. Program designed to assist in initial research efforts in pharmacology, clinical pharmacology or drug toxicology.

- Medical Student Research Fellowships. Began in 1974. Six recipients in 1979. One-year grants for students interested in research and teaching careers in pharmacology.

- Pharmacology-Morphology Fellowships. Began in 1968. Three recipients in 1979. Two-year postdoctoral fellowships to advance understanding of drug action.

- Advanced Predoctoral Fellowships. Began in 1977. Ten recipients in 1979. Program designed to aid candidates with one or two years remaining toward doctorates in pharmacology or toxicology and with thesis research in progress.

The 1979 funding, totaling \$1.035 million, began July 1 for all of the programs except Research Starter Grants and the Predoctoral Fellowships, which commenced Jan. 1, 1979. PMA member firms and other organizations and individuals with an interest in health care provide the grant money, which has exceeded \$1 million for the second consecutive year in the foundation's 13-year history. About \$9 million has been awarded since 1965, and 525 recipients have benefited.

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BOOK REVIEWS

Birth of a Family: The New Role Of the Father in Childbirth

Nathan Cabot Hale. Copyright 1979, Anchor Press/Doubleday, New York, N.Y. 10017. 208 pages, \$7.95.

This publication is written by a layman with special emphasis as to the father's point of view and the role that the father should take in the process of childbirth and establishing the family.

The basis of the discussion involves the added importance and the need of the male person to become more interested and to assume more responsibility in this, the fulfillment and the finalizing of the natural process of child bearing.

The author has shown a great deal of research and soul searching effort to publish an account of the father's point of view and the joy achieved by experiencing the prenatal, the actual birth and the postnatal procedures.

In the past, forming a family was purely the result of the wife's function in conceiving, carrying and delivery of a baby and the end result was the making of a father. More recently, efforts have been extended to include the husband in all facets of the state of pregnancy and the added role he should play in the natural phenomenon. It has now become part of the routine care of the expectant mother to increase the education and training of the husband in the area of the entire process, and most physicians are now recommending the technique as set forth by Dr. Frederick Leboyer—that is, a specific method of natural child-

birth that is most gentle for the infant and rewarding for the mother and father.

Nathan Hale has stated in his book that he has attempted to bring out the father's point of view regarding the "Birth of a Family" and that it in no way is meant to be a medical textbook but is the result of a layman's extensive study and personal observations with several couples and their relationship and care given to them by a well known Boston physician.

The book is very well written and is the only such publication, to my knowledge, which is directed to the "man" and the need of him becoming a part of the increasing desire of the profession, through closer observation and science, to prevent the many complications and unwanted birth defects which have clouded the picture in the past but are now being given much needed attention. The author has certainly given his all in writing such an inclusive and thorough documentation of a common procedure.

Because of the nature of the contents and the depth of the explanations, it becomes necessary to reread various parts of the book for full comprehension and to overlook the repetition of facts throughout the script because of the similarity of findings and observations of the couples explored.

I can recommend this book as a source of information and guidance for the practitioner who is interested in the "Birth of a Family."

IRVIN W. WILKENS, M.D.
Indianapolis
Internist

Clinical Cardiology: 2nd Edition

M. Sokolow and M. B. McIlroy. Copyright 1979, Lange Medical Publications, Los Altos, Calif. 94022. 718 pages, \$17.50.

Alive with the stimulating compression of thought characteristic of most Lange publications, CLINICAL CARDIOLOGY nevertheless emerges as a plus-minus book. On the plus side, it demonstrates a remarkable power to assimilate and organize basic cardiologic information. This new edition revises its coverage of pericardial and myocardial diseases, augments discussion of the "click-murmur" syndrome and antiarrhythmic drugs, and updates its recommendations regarding endocarditis prophylaxis.

The authors' philosophical devotion to the coherence of cardiologic thought, however, leads to some problems. Should they present equally balanced sides to each controversial area? Or should they dogmatize? For example, their apparent bewilderment about what's right regarding coronary artery bypass leads them to

discuss this subject in an ambivalent, excessively conservative manner. Readers seeking more current information about whom to catheterize and whom to operate upon might better read standard textbooks, such as the new edition of THE HEART by Hurst and Logue.

The reportage of some topics, e.g., intra-aortic balloons, can be compared with a woman's bikini—it reveals enough to maintain interest, while concealing the vital parts. For instance, the indications and contraindications for balloon counterpulsation in cardiogenic shock or infarct size reduction are omitted. This is not to imply that the book is a chaotic venture in half-thoughts. The nature of the summarizing task itself makes this book selective by necessity. And, by and large, the text is in perpetual intellectual motion. Apercu and ideas blend pleasantly with fact and generality.

ALAN T. MARTY, M.D.
Evansville
Cardiovascular Surgeon

The Year Book of Surgery 1978

Edited by Seymour I. Schwartz, M.D. Copyright 1978, Year Book Medical Publishers, Inc., Chicago. 523 pages, with illustrations.

If "what's new" was the only unifying theme, this yearbook could easily elude meaningful summarization. Critical analysis would then be limited to picayune comments about whether the editors have selected the best from the 1977 surgical literature. Fortunately, the six professorial annotators intellectually explore each abstract with such vigor that we are again treated to a book worth reading for the fine print. Thus, besides updating us, this book also teaches how to dissect clear from sloppy thinking.

Highlights include the following. Albumin infusions are still being overused, cause complications, and waste money. Essential fatty acid deficiency is common. It can be treated by parenteral lipids or more simply by applying safflower oil to the skin. Peritoneal fluid al-

kaline phosphatase levels may indicate small bowel injury. Infected wounds containing vascular prostheses are being healed without extensive surgery.

A feeling of depression still dominates the immunotherapeutic community—the subject now appears hopelessly complex. The heyday of superior mesenteric arterial pitressin for esophageal variceal bleeding is over. Intravenous pitressin is safer and equally effective. Cellulose granulomas from disposable fabric lint are emerging as an important modern cause of intestinal obstruction. Enthusiasm for the continuous peritoneal-jugular shunt for ascites continues. And new syndromes associated with pancreatic islet tumors have been discovered—e.g., somatostatin producing tumors may cause adult onset diabetes.

In conclusion, this book successfully accomplishes its goals, and can be recommended without hesitation.

ALAN T. MARTY, M.D.
Evansville
Cardiovascular Surgeon

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NEWS NOTES

'Indiana Plan'; A Giant Step For Health Care Delivery

Since the "Indiana Statewide Medical Education System" was implemented in 1967 as a means of dealing with a doctor shortage, the system has won the acclaim of the international medical community, according to a progress report prepared by the Indiana University School of Medicine. For example:

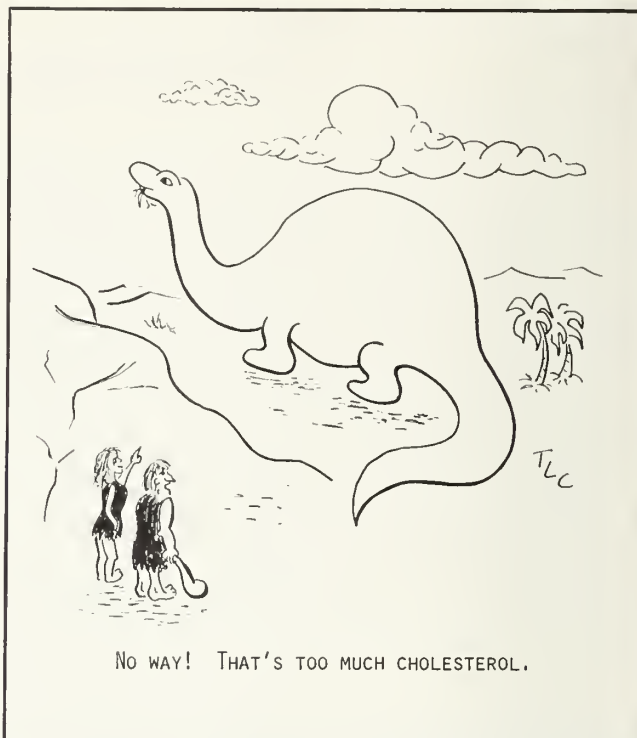
- The number of physicians performing residency and intern work in Indiana hospitals jumped from 428 in 1967 to 927 last year.

- Since 1975, more than 140 freshman medical students have been enrolled in classes at Indiana's eight regional Centers for Medical Education.

- Residency programs are now available in 22 hospitals in eight cities in Indiana as a result of accelerated statewide emphasis on postgraduate opportunities.

- In 1974, there were seven Family Medicine residency programs in Indiana, with 35 physicians enrolled. Today, there are 13 Family Medicine programs, with 202 physicians enrolled.

For a closer look at this "Indiana Plan," read THE JOURNAL's related editorial on Page 8.



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ACEP Moving to Dallas

The American College of Emergency Physicians will move its headquarters to Dallas sometime this year. The move from Lansing, Mich., was motivated by a desire for a major metropolitan area with major passenger carriers, a favorable climatic and economic environment, and an acceptable cost of living.

Infant Formula Problems

Over the past several months, infant formulas have been involved in an increasing number of health-related problems. Ranging from nutrient deficiencies to processing breakdowns, these events have served to focus attention on procedures necessary to assure the quality and safety of these products.

FDA advises that all hospitals and other health facilities immediately begin to evaluate their procedures for storage, distribution, and preparation of infant formulas to identify possible points of contamination and/or reduction in nutritive value.

In addition, FDA needs to have more information on infant illnesses in which formulas may be implicated. The Agency would welcome information on the clinical nature of such illnesses, any supportive laboratory findings, the product or products that may be involved, the time that the problem occurred, and the length of time the formula was used. This information should be sent to FDA's Bureau of Foods, HFF-1, 200 C Street, S.W., Washington, D.C. 20204.

Denies Medical Ethics Prohibit Physician Advertising

Dr. Arvine G. Popplewell, ISMA president, is stressing that medical ethics do not now nor have they ever prohibited advertising by physicians.

"Simply because physicians have not chosen to advertise in any great numbers should not lead to the conclusion that they are in fact prohibited from advertising," he said in response to a recent ruling by the FTC that states the AMA must permit the nation's doctors to advertise. "By filing its complaint, the FTC apparently has chosen to ignore the facts and pursue its foregone conclusions," Dr. Popplewell declared.

He said the Principles of Medical Ethics (as published in the AMA's *Judicial Council Opinions and Reports*, April 1976) are intended to discourage abusive practices that exploit patients and the public, and interfere with freedom in making an informed choice of physicians and free competition among physicians. Moreover, he noted that they are not legally binding on any physician, although they do exert a strong influence over his behavior.

In answer to the charge by the FTC that the AMA has severely inhibited competition among doctors and caused substantial economic harm to consumers, Dr. Popplewell said that physicians are free to supply, at their own options, fee information that may include a physician's charge for a standard office visit or his fee or range of fees for specific types of services.

"It is our opinion," he concluded, "that the FTC in making this rule has chosen to ignore sound principles of medical ethics established in 1957 and revised to include advertising in 1976 which have never prohibited physicians from advertising."

Jail Health Project

The AMA Jail Health Project resulted in a 70% increase in the overall availability of seven of the most important health care services, according to a status report on the first phase of the program. During this three-year period standards were developed and accreditation procedures established.

Among the changes in jail health care following implementation of the AMA standards was a fourfold improvement in early detection of illness, including communicable diseases, through screening of inmates on admission followed by full physical examination.

The second stage of the project, now underway, aims at widespread implementation of the AMA standards. About 350 jails will be involved in 22 states and Puerto Rico.

Fellowships

The following ISMA members have been named fellows of the **American Academy of Family Physicians:**

Dr. Edward L. Langston, Flora;
Dr. George W. Merkle, Bluffton;
Dr. Harold M. Manifold, Muncie;
Dr. L. P. Musngi, Pendleton;
Dr. James D. Payne, New Albany;
Dr. James L. Peters, Shelbyville;
Dr. James R. Roth, Wolf Lake;
Dr. V. J. Tadatada, Salem.

The following ISMA members have been named fellows of the **American College of Surgeons:**

Dr. Paulino Y. Chan, Munster;
Dr. Richard F. Graffis, Indianapolis;
Dr. Randall C. Morgan, Jr., Gary;
Dr. Raymond J. O'Brien, Michigan City;
Dr. Upendra H. Patel, Munster;
Dr. K. V. Pillay, Merrillville;
Dr. Haroon M. Qazi, Indianapolis;
Dr. George D. Smalls, Gary;
Dr. Donald L. Wilson, Indianapolis.

Inducted as a fellow of the **American College of Cardiology** was Dr. Henry G. Giragos, Munster.

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NEWS NOTES

Dr. Corcoran Is AMA Keynoter

Dr. Patrick J. V. Corcoran of Evansville, an ISMA delegate to the AMA, presented the keynote address during the AMA's seventh annual Conference on Continuing Medical Education, held in Chicago in October.

Dr. Corcoran, a member of the AMA Council on Medical Education, highlighted the differences between CME and undergraduate medical education and pointed out that physicians best know their own needs as professionals.

The conference considered the objectives of continuing medical education, mandatory continuing medical education, the Physician's Recognition Award program, categories of credit and the use and misuse of programs of continuing medical education.

Cancer Manual Available

Copies of "Manual for Staging of Cancer 1978" may be obtained by writing the publishing committee—American Joint Committee, 55 E. Erie St., Chicago 60611. Two fascicles, "Staging System for Cancer at Gynecologic Sites" and "Reporting of Cancer Survival and End Results," parts of the complete manual, also are published separately. The manual and the separate fascicles may be obtained at no charge.

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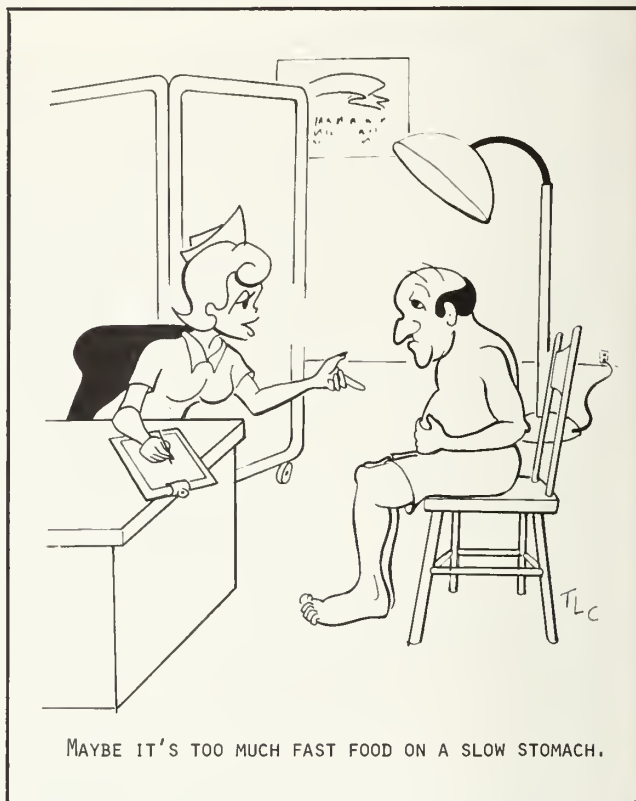
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Diplomates

The following ISMA members have been named diplomates of the American Board of Family Practice:

Dr. Norman E. Beaver, Lafayette;
Dr. Quentin B. Emerson, Evansville;
Dr. Cesar M. Gomez, Munster;
Dr. Jack L. Lenox, Lebanon;
Dr. John A. McQuade, South Bend;
Dr. William L. Meyers, Syracuse;
Dr. Donald C. Miller, Cedar Lake;
Dr. William A. Misch, Cedar Lake;
Dr. W. David Pepple, Auburn;
Dr. James O. Scamahorn, Pittsboro;
Dr. Alan D. Snell, South Bend;
Dr. Brian D. Zurcher, Fort Wayne.

ACS Offers 1979 Factbook

The American College of Surgeons has published the 1979 edition of *Socio-Economic Factbook for Surgery*. The 95-page booklet, free of charge, provides descriptive and statistical information on surgical manpower, use of medical services, and medical economics. The data cover medical education, resident training, surgical manpower, surgical operations, health expenditures, health insurance and socio-economic issues.

Write to Dept. of Surgical Practice, American College of Surgeons, 55 E. Erie St., Chicago 60611.

Here and There . . .

. . . **Dr. Maurice E. Rougraff** of Noblesville has been appointed medical director, American United Life Insurance Co. of Indianapolis. He is directing the company's mortality study on exercise electrocardiograms.

. . . **Dr. John A. Knote** of Lafayette, recently elected chairman of the ISMA Board of Trustees, has been elected president of the Indiana Roentgen Society, Inc., a chapter of the American College of Radiology.

. . . **Dr. Richard G. Huber** of Bedford, an ISMA alternate trustee for the Third District, has been elected president of the Lawrence County Mental Health Association.

. . . **Dr. Marcella Modisett** of Madison has been named winner of the 1979 Community Service Award, presented by the Madison Area Chamber of Commerce.

. . . **Dr. Frederick A. Hillis** of Logansport has been named Cass County health officer. He succeeded his father, **Dr. Lowell J. Hillis**, who resigned after holding the position 20 years.

. . . **Dr. Gerald C. Walthall** of Indianapolis has been appointed to the state's Hearing Aid Dealer Advisory Committee, and **Dr. John A. Bowman** of Kokomo has been appointed to the Indiana Community Mental Health Planning Advisory Council.

. . . **Dr. J. C. Bacala** of Scottsburg has been elected president of the American College of International Physicians. **Dr. Eusebio C. Kho**, also of Scottsburg, was elected to the college's board of trustees. The ACIP is an organization of foreign medical graduates who are now licensed and practicing in the U.S.

. . . **Dr. J. Terry Ernest** has been named chairman of the Dept. of Ophthalmology, I.U. School of Medicine, succeeding **Dr. Fred Wilson**, who retired. Most recently, Dr. Ernest was professor of ophthalmology at the University of Wisconsin.

. . . **Dr. Ott B. McAtee** has retired after 27 years as superintendent of the Madison State Hospital. Dr. McAtee, 77, is opening an office in Madison for the private practice of psychiatry and neurology.

. . . **Dr. Felipe S. Chua** of Valparaiso has been elected president for 1982-83 of the medical staff at St. Anthony Medical Center, Crown Point. Dr. Chua also is president-elect of the Society of Philippine Surgeons in America.

. . . **Dr. Harris B. Shumacker, Jr.**, an Indianapolis cardiovascular surgeon, recently completed a month-long trip to China with a teaching delegation from the American College of Physicians.

. . . **Dr. E. Briscoe Lett** of Loogootee has been appointed by Governor Bowen as a Sagamore of the Wabash. Last year he was chosen Martin County's "Senior Citizen of the Year."

Catheter Guide Available

A guide that details the measuring capabilities of the Swan-Ganz® catheter, cardiac output and the clinical applications of hemodynamic measurements is now available from Hewlett-Packard.

The 40-page guide, which sells for \$6, is easy to use and is well diagrammed with 26 figures and tables. The title is *A Guide to Hemodynamic Monitoring Using the Swan-Ganz® Catheter*.

Address: Inquiries Manager, 175 Wyman St., Waltham, Mass. 02154.



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Court Action

Patient's Malpractice Suit Barred by Time Limit

The statute of limitations began to run when a patient failed to follow his physician's advice to see a specialist and barred the patient's malpractice action, an Indiana appellate court has ruled.

The patient was injured in August 1971 when a window glass fell on him and broke. Pieces of glass penetrated his neck. A physician cleaned and sutured his wounds, and he later returned to have the stitches removed. On Oct. 16, 1973 the patient returned to the physician and complained of low back pain, pain in the sciatic area, and pain in the left leg. As a result, the physician made an appointment for the patient with a specialist. The patient failed to keep the appointment and instead consulted a chiropractor.

In March 1974 the patient returned to the clinic. A second physician examined him and referred him to another specialist. The patient kept

Courtesy of THE CITATION, Nov. 15, 1979.

this appointment, and the specialist found that a piece of glass had worked its way into the patient's spinal canal and caused his weakened, degenerative condition.

On April 5, 1976 the patient filed a malpractice suit against the clinic and the physician. After nine months of pretrial motions, a trial court granted summary judgment on the ground that the action was barred by the two-year statute of limitations.

On appeal, the decision was affirmed. The two-year limitations period began to run in October 1973 when the patient failed to take the course of action recommended by his physician. There was no evidence of concealment or any other exception to prevent the application of the statute. Since the suit was filed well beyond the two-year period, it was barred.—*Snyder v. Tell City Clinic*, 391 N.E.2d 623 (Ind. Ct. of App., June 27, 1979)

Physician Recognition Awards

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

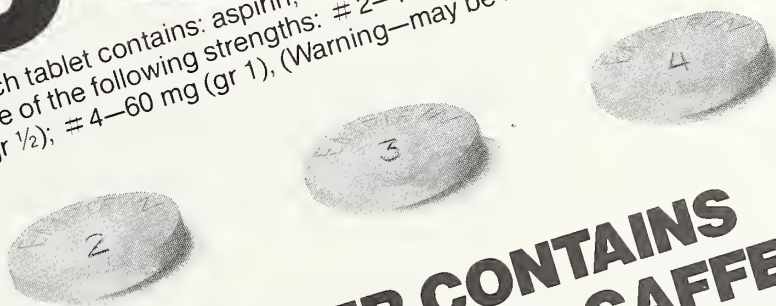
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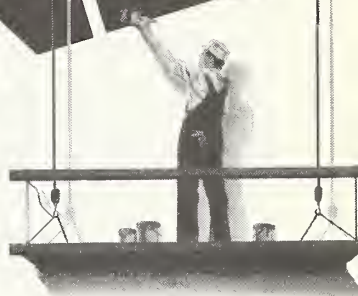
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OBITUARIES

Walter C. Anderson, M.D.

Dr. Anderson, 78, a retired Terre Haute physician, died Oct. 19 in Union Hospital, Terre Haute.

He was a 1926 graduate of the Indiana University School of Medicine and was an Army veteran of World War II.

Robert D. Berke, M.D.

Dr. Berke, 69, a South Bend allergist, died Nov. 12 at his home.

He was a 1936 graduate of the University of Illinois School of Medicine.

Dr. Berke was a diplomate of the American Board of Allergy and Immunology.

Robert M. Dearmin, M.D.

Dr. Dearmin, 80, a retired Indianapolis otolaryngologist, died Nov. 13 at his home.

He was a 1924 graduate of the Indiana University School of Medicine.

Dr. Dearmin, a World War II veteran, headed the ear, nose and throat division at Wishard Memorial Hospital 20 years ago. He had been on the teaching staff of the I.U. Medical Center before retiring three years ago.

He was a fellow of the American Academy of Otolaryngology and was a senior member of the ISMA. He was enrolled in the 50-Year Club in 1974.

Robert W. Reid, M.D.

Dr. Reid, 92, a retired Union City physician, died Oct. 30 at Ball Memorial Hospital, Muncie.

He received his M.D. degree in 1912 from the University of Cincinnati. Except for Army service during World War I, he practiced in Union City from 1914 until 1953. For the next ten years he served Union City Memorial and Randolph County hospitals as a roentgenologist.

Dr. Reid was a past president of the Randolph County Medical Society. He was a senior member of the ISMA and joined the 50-Year Club in 1962.

Danny D. Swihart, M.D.

Dr. Swihart, 49, an Elkhart physician, died Dec. 1 at St. Vincent Hospital, Indianapolis.

He was a 1954 graduate of the Indiana University School of Medicine.

Dr. Swihart was vice chief of staff at Elkhart General Hospital and a member of the Simpson Medical Group. He also was a member of the American Academy of Family Physicians.

John W. Visher, M.D.

Dr. Visher, 88, a retired Evansville physician, died Oct. 31 at St. Mary's Medical Center, Evansville.

He was a 1917 graduate of Rush Medical College, Chicago. He moved to Evansville and began his private practice there in 1928.

Dr. Visher, who retired five years ago, was a member of the American Academy of Family Physicians. He was a senior member of the ISMA and was enrolled in the 50-Year Club in 1966.

Nelson A. Wolfe, M.D.

Dr. Wolfe, 59, a New Albany physician, died of an apparent "heart attack" Oct. 31. He died as four intruders robbed his home after binding him, his wife and daughter, police said.

Dr. Wolfe, who earned his M.D. degree in 1943 at the University of Louisville, had recently undergone coronary bypass surgery.

He was a past president of the Floyd County Medical Society and was a member of the American Academy of Family Physicians.

Grant E. Metcalfe, M.D.

Dr. Metcalfe, 73, a South Bend psychiatrist, died Nov. 15.

He was a 1930 graduate of Hahnemann Medical College of Philadelphia.

Dr. Metcalfe, certified by the American Board of Psychiatry and Neurology, was a senior member of the ISMA. He also was a member of the American Psychiatric Association and the American Psychosomatic Society.

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February 1980 • Vol. 73 • No. 2

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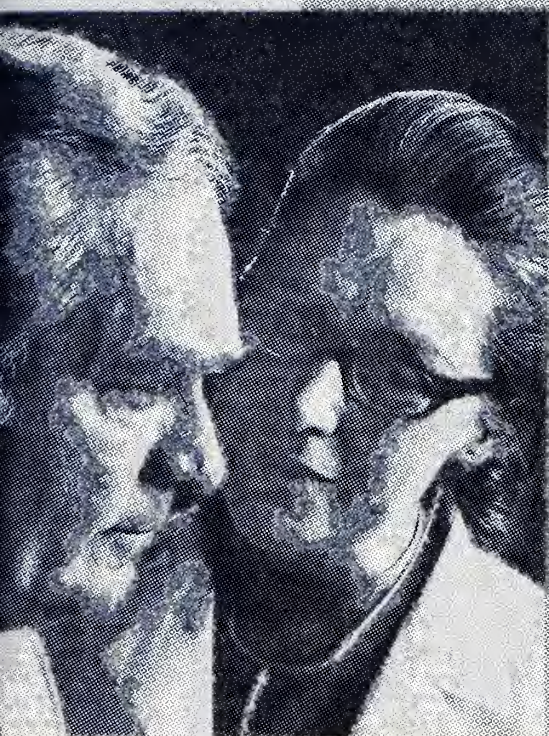
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Indications: Relief of anxiety and tension occurring alone or accompanying various disease states. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended

Contraindications: Patients with known hypersensitivity to the drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d., severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available singly and in trays of 10. Libritabs® (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche Products Inc.
Manati, Puerto Rico 00701

WHAT'S NEW?

THE 3M COMPANY introduces Glutarex, a disinfecting and sterilizing solution which is efficacious even when diluted to a low concentration of the active component glutaraldehyde. It is intended for disinfection of cystoscopes, fiber optic endoscopes, anesthesia and respiratory equipment and decontamination of instruments.

McNEIL LABORATORIES is introducing TOLECTIN® DS (tolmetin sodium) double-strength 400 mg capsules. The new dosage form provides easier administration and improves patient compliance. The larger starting dose rapidly relieves stiffness and pain of osteoarthritis and rheumatoid arthritis.

"AUTOMATIC" SPRINKLER CORPORATION has a Halex® 1301 fire protection system for records and equipment storage areas. It depends upon the release, in case of fire, of Halon 1301, a halogenated hydrocarbon stored under pressure as a liquid and released as a gas. The gas is harmless to people and property and extinguishes a fire in seconds.

DIGITAL TELEPHONE SYSTEMS announces a new computerized telephone switching system for smaller hospitals and clinics with from 8 to 55 phones. It is called the DLS-1™ "Protocol"™ system. It is built around an advanced Texas Instruments' micro-computer. It is easy to operate and even permits use without a console or attendant.

NUCLEAR-MEDICAL LABORATORIES has published a brochure entitled *Why Early Pregnancy Testing?* The 12-page publication discusses HCG (The hormone of pregnancy) and how its detection in urine or serum is the basis for testing. Also, five critical situations are discussed in which early testing is essential. The brochure may be obtained by physicians, free of charge, by writing NML at 8700 N. Stemmons Freeway, P.O. Box 47864, Dallas 75247.

THE 1980 DIRECTORY of medical films, audiovisuals, and medical education resources available from Norwich-Eaton Pharmaceuticals lists 10 new 16mm films and five 35mm slide/audio cassette tape programs. These are available on a free loan basis. The directory also lists other films and slide programs of previous years. Contact a Norwich-Eaton professional representative or write the company at Norwich, New York for a free copy of the directory.

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News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

WINNER
Sandoz Medical Journalism Award—1976, 1979

Vol. 73, No. 2
FEBRUARY 1980

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ISSN 0019-6770

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POSTMASTER: Send address changes to THE JOURNAL, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

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All issues since 1967 available on microfilm from University Microfilms, Inc., 300 N. Zeeb Rd., Ann Arbor, Mich. 48106. Indexed in Index Medicus and Hospital Literature Index.

Advertising rates and data available on request. Representative for national advertising: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302.

Publication deadline: 1st day of month preceding month of issue.

Subscriptions: \$14 per year, USA; \$16, Canada; \$17, foreign; \$12, libraries; \$10, senior ISMA members; \$8, members; except for special issues, single copies not available. Subscriptions renewable only in January and July.

Second-class postage paid at Indianapolis Ind. and additional mailing office.

ABOUT THE COVER

Skiing is one of the sports offered at Pokagon State Park, located near Angola on U.S. 27 and I-69. Other winter attractions include ice skating, ice boating and tobogganing.

PHOTO COURTESY INDIANA DEPT. OF COMMERCE



MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

1847 Charge for Two House Calls: \$2.20

According to Kemper, the first ovariectomy in Indiana was done by Dr. John Sloan of New Albany. This was reported in the *Transactions of the Indiana State Medical Society* on page 55 of the 1852 volume.

Kemper (*Medical History of Indiana*, p. 361, AMA Press, Chicago 1911) tells us that Dr. Sloan's patient was 33 years old at the time, and that the surgery was done Feb. 18, 1852. Dr. Kemper doesn't give the patient's name, nor does he tell us of her long-term survival. He does describe the surgery with these comments:

"(Dr. Sloan) was assisted by Doctors Leonard, Shields, Town, Graham, Bowman, and Rucker. Chloroform was administered by Dr. Bowman. Dr. Sloan made an incision in the linea alba five inches in length down to the peritoneum, and this was divided on a director. The tumor, being composed of considerable solid substance, Dr. Sloan extended his incision one-and-a-half inches above the umbilicus and downward to the pubes. A double ligature was passed through the pedicle and tied on either side. On March 20 the wound was entirely

healed, and she was walking about the house."

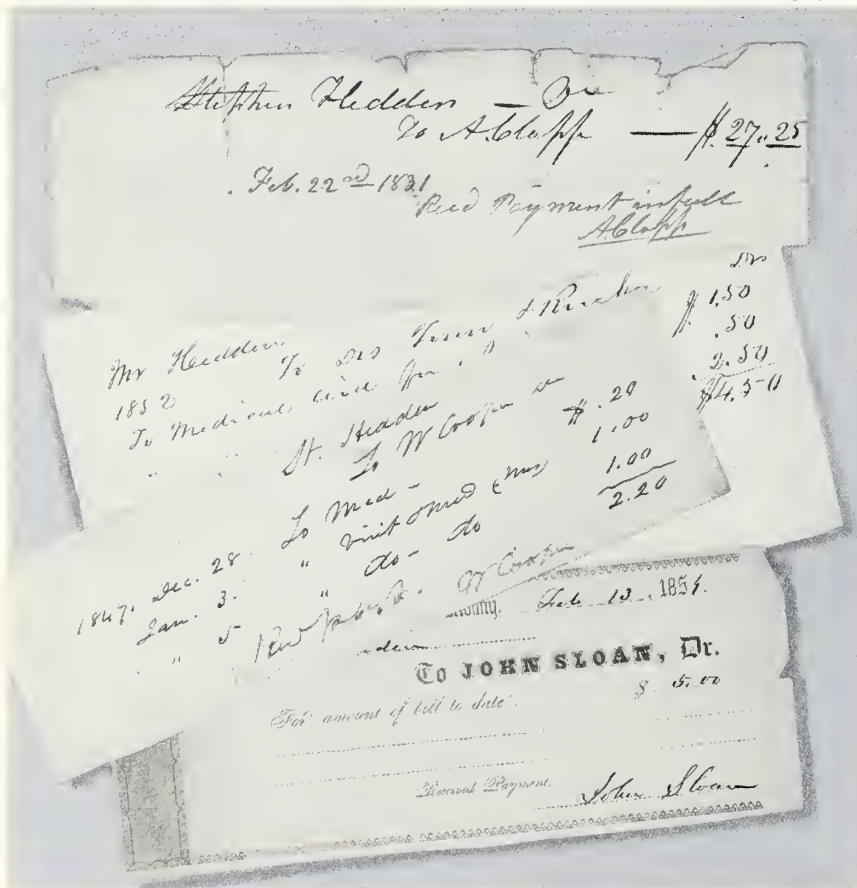
Eighty-five years after this event (March 24, 1937) another New Albany physician, Dr. R. W. Harris, sent a letter to Mr. Thomas Hendricks, secretary of the Indiana State Medical Association: "I am herewith enclosing you a few receipts for medical services rendered in the past century by physicians in New Albany . . ." Among these receipts is one of Dr. Sloan and one of Dr. Town and Dr. Rucker.

Another receipt is that of Dr. William Cooper (who was graduated from Jefferson Medical College in 1834).

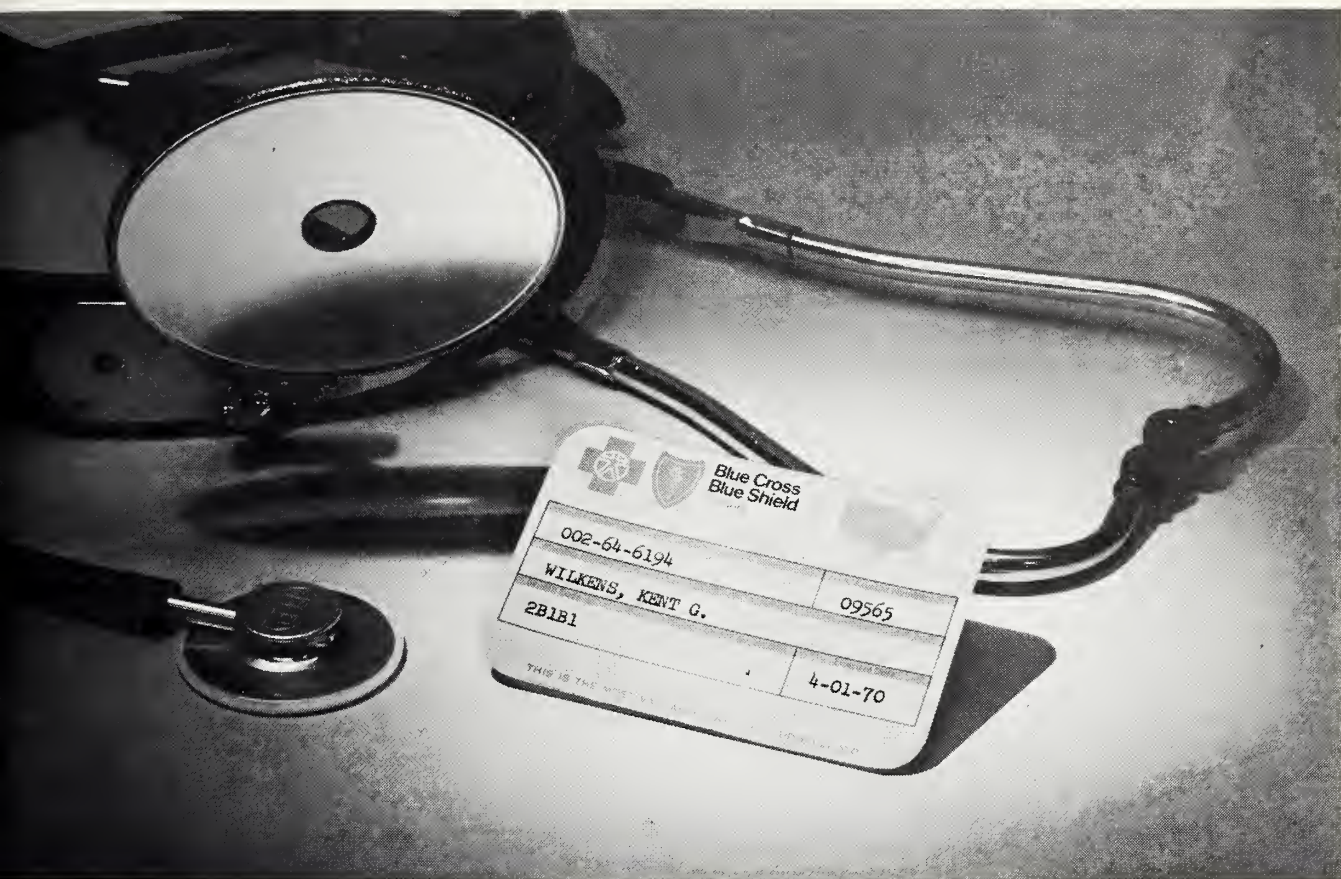
The fourth receipt is the oldest—Feb. 22, 1831, from Dr. Asahel Clapp (*Medical Museum Notes*, April 1978).

These receipts were placed in a file in the safe of the Medical Association Office, where they remained for over 40 years. These receipts have now been given to the Museum.

The common denominator to all these receipts is the fact that they were issued to members of the Hedden family. Dr. Clapp's bill for \$27.25 is the largest. The services are not itemized. Dr. Cooper's bill, dated Dec. 28, 1847, records a charge of \$2.20 for two house calls and medication. Drs. Town's and Rucker's bill, dated Dec. 2, 1852, is \$4.50. Three members of the family were treated, fees ranging individually from \$.50 to \$2.50. Dr. Sloan's receipt, dated Feb. 13, 1854, is the most recent and most modern. The nature of the \$5 fee is not listed.



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LETTERS

'Comforting Certainties'— Magic in Medicine?

Concerning the guest editorial by Dr. D. L. Stewart in the October 1979 issue of *THE JOURNAL* ("Comforting Certainties," Page 743), I would like to take exception to certain premises and attitudinal positions taken by Dr. Stewart which I believe could be detrimental to the improvement of medicine in our country.

Throughout Dr. Stewart's editorial, he speaks of instinctive actions taken by the part of physicians toward their patients and speaks of these in a rather approving manner. While such actions may be taken, they must be considered as non-verbalized responses to non-verbalized clues in patients' symptomatology and not indeed inborn behavioral patterns on the part of physicians which by definition an instinctive action would be.

He also speaks of inexplicable cures, and while I agree that these are indeed awe inspiring, I believe

Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is encouraged. Letters should be addressed c/o *THE JOURNAL* of the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

that we should always attempt to seek out the reasons for such inexplicable cures so that progress can be made.

Finally, Dr. Stewart takes an attitude which I believe is anti-scientific and detrimental. He speaks of a knowledge which cannot be obtained as a result of study or of reading books. It would be my contention that there is no such knowledge and that all knowledge can and should be transmitted. While we do not always have a full explanation for everything we see, we should, in fact, strive to obtain these, recognizing our present limitations.

In short, there should be no appeal to magic in medicine. Where medicine is an art is in the application of scientific principles to individual cases and to individuals whose reactions are frequently tempered by emotions.

ARTHUR LORBER, M.D.
Harcourt Clinic, Inc.
Indianapolis

The Author Replies— Intuition Cannot Be Created

It is gratifying to have a busy young orthopedic surgeon take time to respond to the guest editorial, "Comforting Certainties." I surely view with dismay the possibility that I have, at this point in life, actually become not just nonscientific but, even worse, antiscientific and detrimental to the improvement of medicine. May my heirs never hear!

Dr. Lorber is, of course, quite right in complaining of my use of the word "instinctive." We humans

CONTINUED ON PAGE 73

THE INDIANA STATE MEDICAL ASSOCIATION

1980 Annual Meeting—Oct. 17-20—Indianapolis

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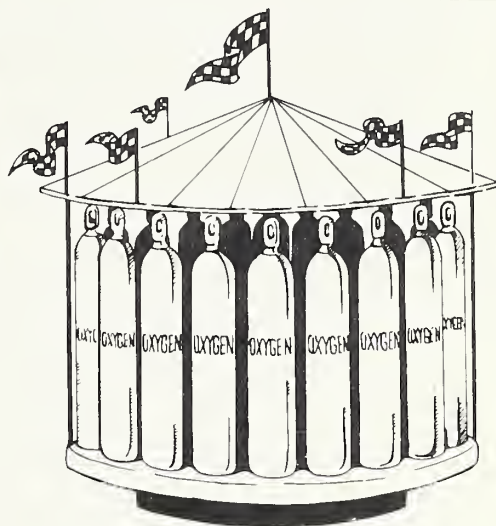
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Ft. Wayne, Indiana
Phone 1-219-432-3321

WHAT'S NEW?

CONTINUED FROM PAGE 62

SEARLE recently introduced Dulocil (suloctidil), a drug used to treat symptoms of arteriosclerosis, in Argentina. The drug has been marketed in Brazil since 1978 and in Mexico since 1977. Dulocil is a peripheral vasodilator.

SCHERING is introducing Theovent Long-Acting Capsules, a long-acting pure anhydrous theophylline. The preparation is recommended for children 6 years of age and older and adults for relief and/or prevention of reversible bronchospasm associated with asthma, chronic bronchitis or emphysema. Full dosage information, contraindications and side effects are covered in the product information sheet.

EXTRACORPOREAL Medical Specialties, Inc. announces the EX®-85 ClearCase™ parallel plate dialyzer. The EX-85's transparent case aids in reducing residual blood loss and helps minimize the amount of saline needed to clear the unit of residual blood when dialysis is complete. The unit can be used with virtually any negative pressure dialysis system.

MEAD JOHNSON'S Nutritional Division is adding a new liquid Egnog Flavor to its Sustacal line. Sustacal is a nutritionally complete dietary supplement that has been available in chocolate and vanilla flavors for many years. Sustacal is lactose-free to eliminate problems associated with lactose intolerance.

CHARLES BESELER COMPANY makes a portable X-Ray Vu-Graph overhead projector for magnifying the image on a large screen for classroom and discussion groups. Projection up to 12 feet by 15 feet enables a large group to see details which are not evident to a large group when the viewing is on a conventional view box.

DOUBLEDAY has published *Sportsmassage* written by Jack Meagher, a professional masseur of 30 years experience, and Pat Boughton, a writer in the health field. All athletic movement consists of 12 basic body postures, each of which is used to different degrees in different sports. By knowing the four easily learned Sportsmassage strokes, anyone can locate and treat restrictions in the muscle system. 220 pages, 140 black and white drawings, \$6.95, paperback.

UNDERGROUND HOMES of Portsmouth, Ohio, has published a 24-page booklet entitled *The Primer to Earth Sheltered Living*. It outlines the advantages and disadvantages of living underground. Also discusses the factors to consider in selecting a site for the home and guides for selecting the type of underground to build. The primer sells for \$3.00. The company also has a 44-page plan book which contains blueprints and an information manual.

Quinamm™

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

Merrell

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for Knotts in the night



QuinammTM

each tablet contains quinine sulfate 260 mg., aminophylline 195 mg.

specific therapy for painful night leg cramps

Nocturnal recumbency leg muscle cramping is frequently an unwelcome bedfellow for many patients—especially those with arthritis, diabetes or peripheral vascular disease... consider Quinamm... simple, convenient dosage—usually just one tablet at bedtime... can provide restful, welcome sleep without night leg cramps.

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The Alpha Advantage:

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Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido:
2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

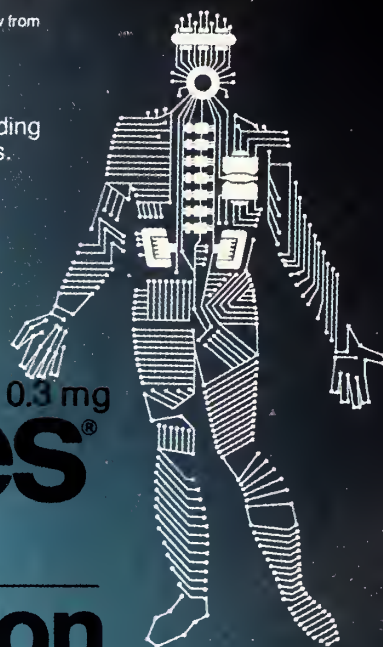
* Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

1. Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new
0.3 mg tablets**

Tablets of 0.1, 0.2, 0.3 mg
Catapres®
(clonidine HCl)
Hypertension

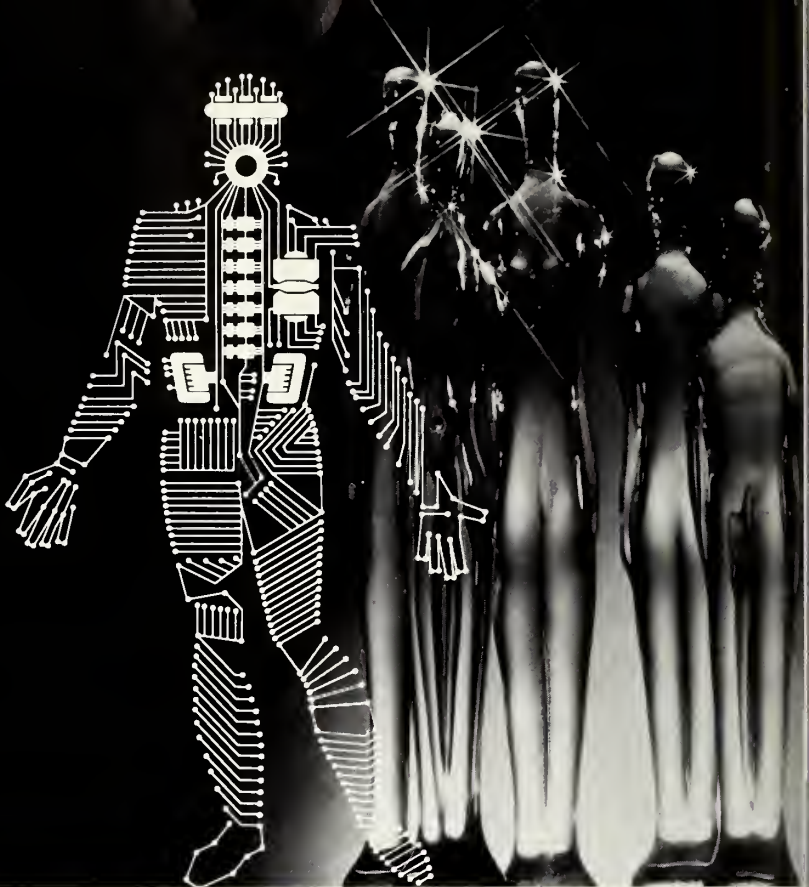




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Tablets of 0.1, 0.2, 0.3 mg
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(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an antihypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness, sedation, constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormal liver function tests; one report of possible drug-induced hepatitis without jaundice and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidomide and papaverine hydrochloride. Weight gain, transient elevation of glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud's phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes, nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished sensor reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) dosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000 available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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AUXILIARY REPORT

Charlotte (Mrs. Abner P.) Bennett
President, ISMA Auxiliary

A recent edition of AMA-ERF's newsletter *The Winning Team* contained a letter from Dr. Hubert A. Ritter, president of AMA-ERF. I'd like to share it with you:

"Contributions to the AMA-ERF from our medical families are up by \$100,000 for the first nine calendar months of 1979. Direct gifts to the Foundation from physicians are up by \$115,000 while gifts through the Auxiliary (as reported on contribution sheets) are down by about \$15,000 from 1978. I am confident that this lag is due to processing delays because I have never felt so much enthusiasm for our efforts, and I know that comes from you. Also, even with the \$15,000 short-fall so far, Auxilians have collected \$665,490.72, a total that is more than \$250,000 ahead of physician contributions to date. I am pleased with us all, but I am especially proud of the work of the Auxiliary.

"Gifts to the student loan guarantee program are up by \$108,000 for the first nine months, for a total of \$268,979.92. This progress is encouraging, but the escalating need among students for our help makes it necessary for me to ask you to make even greater efforts to assist this program.

"While loan volume is down this year because of the interest rate situation and our limit on the number of loans available at any one school, the interest rate will be going down eventually and AMA-ERF would rather not have a limit on the number of loans it can guarantee. Our strong efforts now during this brief period of reduced activity in the program could go a long way to prepare the program for the future on a sound fiscal basis.

"I am sure that it is as obvious to you as it is to me that inflation is making money more difficult to

attract, even for the most worthy programs such as AMA-ERF. To meet our goals, greater efforts will be needed now and in the future, but together we can be successful and we must be to guarantee the continuing excellence of the medical education offered by our schools and the good health of the public we all serve. Let's make this a record year with a very fast finish."

ISMA Auxiliary had an outstanding AMA-ERF 1978-79 year due in no small measure to ISMA's contribution. We may need to escalate our efforts in order to maintain our status quo. You can help Indiana contribute to a fast finish by topping off your contribution with strong support for auxiliary's state project, a Weekend in Las Vegas. When an auxilian approaches you, listen to her, open your billfold—and do just a little bit more to keep your kind of medicine alive and well in the coming year.

LETTERS

CONTINUED FROM PAGE 66

have little that is truly instinctive beyond the sucking of the infant and the pelvic thrust of copulation. Since I was referring, in my use of the word, to neither of these, I stand corrected. Intuition is much the better word to use here, though even this change may not placate Dr. Lorber. In turn, he may wish to reword his definition of where "medicine is an art" since he describes instead a technique.

The skeleton, a no-nonsense system that survives even death and decay, seems an ideal area for Dr.

Lorber's craft. Still, I wonder if he doesn't wish to reconsider his contention that there is no such thing as knowledge that cannot be obtained from study or of reading books. Technique can be taught. Intuition cannot be produced on demand. Honed it can be, but not created. The dedicated and dextrous apprentice can be turned into a skilled craftsman but more subtle ingredients are required if he is to be an artist, too. These will include such things as talent and feeling, intuition and the ability to marvel, all difficult to codify.

I am reminded of a statement of Pasteur's describing his view of his scientific enterprise. He mentioned feeling as if he were, metaphorical-

ly, a child playing on a beach, now and again finding a bright treasure in the sand—while the whole ocean of truth lay just before him, marvelous but uncomprehended.

After all knowledge available in Dr. Lorber's lifetime is written down, organized into disciplines, cleverly recorded and spread to the medical masses, one hopes that at the zenith of his career he will see, intuitively, beyond him a great ocean of truth which he cannot know because life is brief and he is finite. Then, one hopes, he will marvel at what he cannot know.

Basically, that's all this small editorial had to say.

DAVID STEWART, M.D.
Louisville, Ky.

Health at Any Price?

THE HONORABLE KINGMAN BREWSTER
Ambassador of the United States
American Embassy, London

Under my title 'Health at any price?' I intend to focus on a mundane matter: how to pay less for the medical care we receive or how to receive more for what we pay.

At least in my country there is some cause for alarm. Per capita expenditures on medical care have risen from roughly \$200 a year in 1965 to over \$900 a year in 1979. Total national outlay for medical care has risen from 39 billions in 1965 to over 200 billions this year. Whereas we devoted only 6% of our gross national product to medical care in 1965, we now devote almost 10%.

And despite these enormous upward surges of costs and expenditures, in a comparable period we suffered an 8% increase in work days lost due to illness; a 6% increase in school days lost due to illness; a 27% increase in bed disability days. While we spend more on medical care than most nations, five nations do better in preventing deaths from cancer; 10 nations have a lower death rate from circulatory diseases; 16 nations do a better job of keeping infants alive during their first year, and 17 nations have a higher level of life expectancy.

It is true that when I accepted the invitation to give this Lecture it never occurred to me that I would on June 5th find myself in the middle of a controversy between my President and Senator Kennedy on national health policy. It never dawned on me that both of America's national newsmagazines would last week have made the cost of health, or rather the cost of medical care, the feature of their cover stories. Under such circumstances diplomacy would indeed counsel restraint on the President's representative speaking in a foreign land. To the humility which should be the lot

of the dilettante among professionals is now added the inhibition of my current calling.

Diplomatic indirection cannot cover up the vast gulf of my ignorance. I cannot say where I stand because I do not know. I do not know enough to have convictions about, let alone prescribe for, any nation's health policy. Happily that is not my intention. My purpose is, rather, to explore and speculate about the medical economy as just one example among many of the need to find a third way, something more adequate than the free market; something more satisfactory than government direction.

It occurred to me some time ago that we grandsons of the 19th century have been too long hung up on the horns of a classic dilemma. Since the free market is imperfect, the State should take over. Or, since the State makes a dreadful mess of it, we better rely on the free market. In fact, increasingly the work of the world goes on in between. But still the only "models" we have are the models of capitalism and the models of socialism.

I suppose my educated instinct is that of the common law: anti-model. The common-law tradition tends to look for a solution by attending to the practicalities of the problem at hand rather than expecting revelation from some all-embracing concept, or "model".

I would start with two propositions. First, if giving free reign to private acquisitiveness is not serving the public interest, see if there is a way to turn private cupidity to public purpose before having the government take over. Second, in trying to channel private self-interest in the public interest, use the carrot rather than the stick. Incentive is so much more constructive than prohibition.

The question with which I start is: In the medical economy, is it possible that we might devise some regime which is better than the offering of service for a fee by private practitioners on the one hand or the assumption of total responsibility by the State for health care on the other? If the free market has failed can

This paper is an abridged version of the Edwin Stevens Lecture for the Laity delivered by Ambassador Brewster to the Royal Society of Medicine June 5, 1979. Reprinted with permission from the JOURNAL OF THE ROYAL SOCIETY OF MEDICINE, 72:719-723, October 1979.

we perhaps create an artificial market to serve the public interest? If public ownership or public regulation has failed can we perhaps use public financing to create by incentive what we cannot achieve by public management or regulation?

This is a very large question in a great many fields, not just medicine. Maybe it is *the* question for any society which strives to remain or become as voluntary as possible for all its members. On the one hand, a voluntary society cannot tolerate the deprivation and discrimination which untrammelled private power would impose if left wholly to itself. On the other, a society which would be voluntary cannot abide official power to push other people around. Yet such power seems invited by the ever-expanding reach and grasp of government. The medical economy may be an area worth probing to see if there is a third way: the use of the powers of government, not to take over the direction of activity but to create arrangements with built-in incentives designed to achieve the public purpose.

The fact is that modern societies do not want the laws of supply and demand to decide who receives medical care. Even the United States is at last accepting that access

Something more adequate than the free market and more satisfactory than government direction is needed.

to adequate medical care is a right. The "entitlement State" assumes this responsibility.

If the only problem with the operation of the medical market were the inequitable distribution of income, surely we could solve that by subsidizing the poor through vouchers for medical expenses or some form of reimbursement to make the poor richer for this particular purpose. Then let them shop around to find the best care at the lowest cost.

The trouble with this notion is that in my country at least the bills are usually paid, not by the patient but by his insurance company, or by his employer acting as an insurer. The costs of care are so high that the patient—or his employer—is glad to pay a premium for protection against the evil day. The evil days are few enough for the population as a whole,

so that the premiums which the potential patients are willing to pay (or helped by the government to pay) more than cover the costs of the medical care which turns out to be needed. The fear of the cost of illness and the calculation of the actuarial mind can easily be brought into agreement on an ample pre-

Can we perhaps use public financing to create by incentive what we cannot achieve by public management or regulation?

mium. It is even easier if by collective bargaining you can persuade your employer to pay the entire premium for you. One way or another about 95% of all hospital costs in the United States are in fact paid by insurers, and almost half of all doctors' bills are paid either by insurers or by the government under Medicare and Medicaid.

Obviously if someone else is paying the bills there is scarcely any incentive to shop around for the lowest doctors' fees or hospital charges. If this were the only problem, surely ingenuity might devise ways of giving the patient an interest in economizing on medical care, just as though his own money were at stake. Medicare requires the patient to carry a certain percentage of the bills out of his own pocket. The patient could be allowed to redeem his voucher for cash to the extent it was not spent.

Even if by some such fanciful scheme, however, the financial self-interest of the patient could be restored, I doubt very much whether the market would do the job we normally expect of it, to keep the pressure on suppliers to lower their costs lest they lose their customer to a competitor.

The trouble is that the patient, when he thinks something is wrong with him, is not an economic man. He is a fearful, ignorant, helpless, miserable creature. He does want health, almost at *any* price. He is not looking for what the economists call a "provider." He is looking for professional judgment. He cannot begin to compare professional capacity objectively. Next to the quality of professional judgment, the patient wants to feel that the person treating him has no thought other than how best to restore his health. He wants no

second best. He certainly does not want his needs to be weighed against the claims of other patients. The patient, in short, is looking for a trustee, not a "provider".

So too on the physician's side. He is not looking over his shoulder at the costs and quality offered by competing providers when

When he thinks something is wrong with him, the patient is not an economic person. He wants health, almost at any price.

he begins his diagnosis. His judgment about what to prescribe is not a function of examining competitors' "offers" in terms of quality or price. His single motivation is, or should be, how best to discharge his trust as effectively as possible. He too wants to preserve or restore health at almost any price.

Under the American system as it stands, relying on insurance to cover the charges of individual practitioners who set their own fees, it is not hard to see why both patient and doctor will err on the side of doing more rather than less. There is a powerful temptation for the patient to seek care he does not need and for the physician to provide it. Market forces cannot be expected to keep pressure on costs.

Generally, patients do not pay their medical bills; they pay their premiums whether they are sick or well, so when consultation and treatment are resorted to they are already paid for. The patient is not a consumer, he is a beneficiary. The doctor is not a supplier, he is a trustee. Both within broad limits do want health at any price.

The natural reaction to exorbitant and ever rising costs unrestrained by market forces is regulation. Insurance companies would seem to have a financial self-interest in discouraging unnecessary care and preventing wasteful practices and excessive charges. And so they have. This they pursue through endless studies, provision of technical managerial advice, assistance in the measurement of hospital productivity. But when it comes to conditioning reimbursement on proof that care was necessary or provided in an efficient manner, insurers have not been able to do much better than insist that care and the charges for it

should meet some normal and acceptable standard. In practice this can do no more than set a standard of minimal responsibility.

With the introduction of the Federal Government as a source of financing, pressure has mounted for some review of the appropriateness of the care whose cost was met by the government. Professional Standards Review Organizations were established for this purpose. Again, however, such review will give a black mark only to the case of extreme irresponsibility.

If you move to direct cost regulation, whether of hospital costs or physicians' individual charges, as in the case of all regulation it may be necessary to be arbitrary—or at least uniform—in order to be fair. Yet uniformity inevitably fails to take into account the variety of costs which are at least plausibly relevant to the quality of service.

If the state seeks to solve the problem of cost escalation by taking over direct responsibility for the entire medical economy, these problems are translated into management, personnel and budget decisions; but the problems are not markedly different from those of direct regulation of private activity by a government agency.

Cost regulation cannot fairly evaluate the necessity and quality of the care provided, so it cannot fairly determine what its cost should be.

Even if it were appropriate for me to express a judgment about Britain's national health service I would not be qualified to do so. On the one hand I and my fellow countrymen are admiring to the point of envy of any society which can truly say that it has achieved non-discriminatory access to health care for all its citizens. Rationing by queue may be frustrating. And the cash limits on current expenditures and the borrowing limits on capital expenditures may lead to run down and obsolescent facilities. Nevertheless, the widespread sense of fairness in the society on matters of health and illness, even life and death, is and should be a mark of national pride. On the other hand, as in the case of direct regulation of costs and charges, it is almost inevitable that compensation should be regulated

without regard to the infinite variety of the time, attention and anguished moral responsibility which will fall so unevenly among practitioners. Perhaps my favorite witness on this matter is not entirely objective, but I learned more from Enoch Powell's book, *Medicine and Politics*, than from any other I have read on the subject:

"The doctor cannot build up a practice and a reputation that enables him to reap the reward of his efforts either in income or in satisfaction. Paradoxically, the better he does his work, the worse off he is. The money he spends on improving his premises, providing himself with modern equipment, paying for efficient reception, clerical and other administrative staff, will not increase his earnings by one penny. On the contrary, the cost will come out of an income that would have been undiminished if he had spent on none of these things. If he restricts his list to the number of patients he can treat properly and conscientiously, and devotes to consultation the amount of time and care he considers to be required, he cannot recoup himself, as under the old combination of private enterprise with rough-and-ready charity, by 'soaking the rich'. He will merely end up with a lower income than his less able or scrupulous fellows, with the added chagrin of knowing that the money he forgoes will be redistributed among them. The essence of the private enterprise system, competition for gain, has been gouged out of family doctoring, while living in the empty shell."

Government subsidy should be used to encourage the creation of an artificial market for competition among prepaid comprehensive care plans.

Just as the market "failed" because the physician-patient relationship is not one of a seller and a buyer bargaining for each other, so too cost regulation "fails" because it cannot fairly evaluate the necessity and the quality of the care provided and therefore cannot fairly determine what its cost should be.

Is there any way out of this expensive triangle of patient, physician, and government as underwriter? One path of promise would be to have the patient make his medical choice when he is still thinking rationally as an economic man—that is, before he becomes a patient. Instead of paying his premium and being free to spend his insurance payments wherever he wants, ask him to pay a fee for access to comprehensive care offered by a

designated group of physicians. If there are several groups offering their plans for prepaid comprehensive care and there is competition not only in reputation but in the level of fee to be paid, the market might begin to operate.

Recent developments with prepaid comprehensive care offered by a group of salaried doctors have shown promise of startling

Evidence is accumulating that costs are lower for prepaid group plans than for insured fee for service.

economies. While experience is limited, and control groups are hard to define in terms of precise comparability, evidence is accumulating that costs are lower for prepaid group plans than for insured fee for service. I quote from Enthoven (1978): "Luft reviewed and analyzed the many comparison studies done since 1950 and concluded that the cost reduction was on the order of 10 to 40 per cent. The cost savings are mainly attributable to much lower hospitalization rates, and to greater economy and efficiency of operation."

Of course there is a great variety of prepaid group practice. Although the government has sought to facilitate the formation of such Health Maintenance Organizations (HMO), as the legislation calls them, interestingly enough the encouragement comes at a heavy price of red tape. Those groups who have prospered most have developed on their own, without government assistance. Some have been sponsored by employers. This was the origin of the Kaiser-Permanente program, since proliferated under the Kaiser Hospitals and Health Plan. Labor Unions also have become sponsors of so-called HMOs. More recently major universities, especially those with medical centres and affiliated hospitals, have developed comprehensive prepaid health plans.

Competition has already brought new plans into being, often to defend traditional practice against the group invader. In an effort to preserve the freedom to charge fees for service rather than to be compensated by a flat salary, some doctors have sought to organize plans where the organization is billed and ceilings on fees are accepted. If fees do not cover costs, member doctors may accept a pro-rata reduction in fees.

What is the role of government in all this welter of experimentation? The approach which I urge is the use of government subsidy to encourage the creation of an artificial market for competition among prepaid comprehensive care plans. Where competition fails at the point of treatment, let it be created at the point of choice of plan, before the consumer becomes a patient. This could be done by affording more favorable tax treatment for fees paid in advance for comprehensive health care by a designated group than for buying insurance for the payment of medical bills charged on a fee-for-service basis. Then perhaps competition might begin to do its job of keeping the pressure on to offer more and better care for fewer dollars expended. Also, Government could, if it so desired, sharpen the incentives for both patients and doctors.

Even for those whose prepaid fees were subsidized because they could not afford to pay out of their own pocket, an economic self-interest in looking for the most for the least would be whetted if he were permitted to redeem for cash any part of his voucher not expended because of selection of a plan whose charges were below the face value of the voucher. For those well enough off to be paying income tax, a standard tax credit could be provided. Again there would be an incentive to spend as little as possible.

In order to encourage the patient not to resort to unnecessary care it might be further provided that to those whose costs of actual annual care fell below the group average, a rebate would be given, or perhaps a credit against next year's fee.

On the physician's side, as in the Kaiser Plan, the participating doctors could be partners, sharing the risks of loss, sharing the benefits of surplus. Since they have an interest in being fully utilized, presumably they will set their fee as low as possible consistently with a fair return in order to compete favorably with other groups or with physicians charging on a fee-for-service basis. For the same reason they have a large stake in their reputation for effective care. At the same time the partnership interest gives them an incentive to improve efficiency of operation and avoid unnecessary procedures and hospital admissions.

Some might worry that patients might be

dissuaded from seeking the care they needed just in order to settle for a lower fee or to qualify for a rebate. Apart from the somewhat callous consolation that it would be their own fault, I think I have enough confidence in the hypochondria in all mankind to feel that the trade-off between cash and health will give sufficient weight to health.

On the doctors' side there might be a somewhat cynical worry that partners who have a stake in maximizing earnings by reducing outlays against an income of fixed fees would be tempted to take short cuts or to short-change their patients by failing to prescribe expensive care even when it was needed. Ultimately I think I have sufficient faith in the trusteeship motivation, buttressed in this case by long-run self-interest in group as well as individual reputation.

In the search for constructive government responses to market failure other than government regulation or government management, I am inclined to believe that the American contribution will not be any single sweeping answer, but a multiplicity of groping probes, experiments, novel structures and arrangements. The public outcry about excessive rises in medical costs is so great that even the American Medical Association and the American Hospital Association have become much more hospitable to new forms of practice and its financing than they would have been even a few years ago. Out of this welter of development will, I am sure, emerge not an answer but clues to better answers. We dare not attempt a monolithic solution. It would not work. It would not command that disciplined support which a smaller, more homogeneous society can reasonably expect. Our size, our decentralization, our privilege of tens of hundreds of public and private academic institutions focusing on professional and operational problems as well as purely academic and scientific problems, assure a churning of new ideas worthy of experimental test.

By groping pragmatically we may not stumble upon a new and more adequate ideology to compete with either Adam Smith or Karl Marx. But we may find that there are solutions which allow us to keep society more voluntary than it would be under either the rule of the unfettered market or the rule of the all-pervasive State.

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FUTURE FILE

Chronic Pain Seminar

"The Management of Chronic Pain" will be discussed during a day-long seminar Wednesday, March 19, at St. Joseph's Hospital, South Bend.

A registration fee of \$10 includes lunch and coffee. The program is acceptable for 6½ prescribed hours by the AAFP and Category 1 credit toward the AMA's Physician Recognition Award.

For information, contact the Dept. of Medical Education, St. Joseph's Hospital, 811 E. Madison St., South Bend, Ind. 46634. Tel: (219) 237-7111.

National Medical Assn. Meeting

The National Medical Association will hold a combined Region IV and Indiana state meeting at the Hyatt Regency Hotel, Indianapolis, June 19-22.

The topic of the scientific sessions will be "Cancer and the Community," for which 10 hours of CME credit have been approved. Guest speakers will include Robert E. Dawson, M.D., president of the Association, and LaSalle D. Leffall, M.D., immediate past president of the American Cancer Society.

For information, contact Patricia A. Riggs, 3202 N. Meridian St., East Building, Suite 201, Indianapolis 46208, tel: (317) 926-4461.

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Thyroid Disorders Seminar

A half-day discussion on the practical management of thyroid disorders will be presented in Kroot Auditorium, Bartholomew County Hospital, Columbus, Saturday, Feb. 23.

The seminar, beginning at 8 a.m. and lasting until noon, is sponsored by the hospital and by the Departments of Medicine and Surgery, Indiana University School of Medicine. It meets criteria for four credit hours in Category 1 of the AMA's Physician Recognition Award and is acceptable for three and one-half prescribed credit hours by the American Academy of Family Physicians. The registration fee for physicians is \$15.

For information, contact the Division of Continuing Medical Education, Indiana University School of Medicine, 1100 W. Michigan St., Indianapolis 46223.

National Rural Health Conference

Several seminars and CME courses will highlight the 33rd AMA National Conference on Rural Health, which will be held at the Sheraton-Boston, April 17-18.

Physicians can earn up to 15 hours of CME credit by choosing from more than 30 workshops, CME courses and general sessions. The courses will include wound closure, primary management of head trauma, other trauma in agriculture, poisonings, zoonosis, re-plantation microsurgery, sportsmedicine for rural schools, and nutritional assessment and management in rural areas.

For details, contact the Dept. of Meeting Services, AMA, 535 N. Dearborn St., Chicago 60610.

Polytomography of the Temporal Bone

The 22nd two-day symposium on Polytomography of the Temporal Bone will be given under the auspices of the Wright Institute of Otology at Community Hospital, Indianapolis, April 19-20. Participation meets the criteria for 12 AMA Category 1 credit hours. Fee for the course is \$300.

Contact The Wright Institute of Otology, Inc., Community Hospital of Indianapolis, 1500 N. Ritter Ave., Indianapolis 46219. Tel: (317) 353-5679.

Child Care Conference

The 15th Annual Indiana Multidisciplinary Child Care Conference will be held May 21-22 at the Marriott Inn, Indianapolis.

For information, write Morris Green, M.D., 1100 W. Michigan St., Indianapolis 46223.



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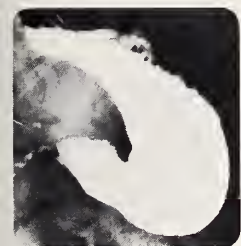
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Pylorospasm has almost totally blocked passage of barium meal.



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"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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Relativity Theory

Guest Editorial

JOHN M. CORBOY, M.D.
Wahiawa, Hawaii

Physicians continue to complain about the weary old 1970 Hawaii Relative Value Study, grumbling that new procedural codes are needed, while old inequities remain uncorrected. They wonder aloud why we don't make a new one.

Well, we did, of course. The 1976 Hawaii Relative Value Study, the tremendous work of Dr. Maurice Nicholson's Fee Survey Committee, was being readied for the printer when the Federal Trade Commission challenged Relative Value Scales as "constituting illegal price fixing" under the Sherman Antitrust Act. This, of course, is pure nonsense.

Since 1977, the FTC has blocked all attempts by specialty groups and medical societies to publish RVS, forcing consent to "discontinue promulgation or publication of relative value studies, schedules or guides." Failure to heed the agency carries a \$10,000 fine per day!

Reprinted with permission from the Hawaii Medical Journal, Honolulu, in which this guest editorial appeared in August 1979.

All efforts by the AMA and others to secure legislation confirming the authority of our profession to develop and use RVS have been to no avail. But the Justice Department lost its recent test suit against the American Society of Anesthesiologists, which had refused to "consent" to the FTC order. Societies which did "consent" remain muzzled, however, until a decision is reached on appeal.

But the Hawaii Medical Association, which did not consent, technically retains a right to publish relativity scales, which the federal judge agreed was "a testament to the need for a cohesive, internally consistent, logical, and appropriate methodology . . ."

Should we publish (and possibly perish), or continue to cautiously await further developments? The mood may be shifting to a bolder position, one of getting on with our necessary business and ignoring the bureaucracy: "Publish and be damned!"

The irony in all this is that government agencies from HEW to DSS freely publish and use all kinds of medical fee schedules because they're absolutely necessary, and now the feds are proposing national scales. But for physicians to compare the relative complexity of an appendectomy vs. a tonsillectomy is illegal! How can something be at once both legal and illegal? Because government agencies commonly issue contradictory orders these days; it needn't make sense, it's government. You might say that it's all relative.

There's a Word for It

VISCO-ELASTIC

RICHARD J. NOVEROSKE, M.D.
Evansville

Soft tissue is sometimes called "visco-elastic tissue" in an effort to describe some of its scientific properties and contrast it with bone.

As I read the definitions of *visco-elastic* I get confused, for I don't know enough bio-physics to understand all of the parts of the definitions. I suspect some other physicians also get confused.

It helps for me to think of a *viscous* semi-solid as one that will "creep" or move slowly, not flow like the usual flow of a liquid or gas—the fluid states of matter. And when I think of the term *elastic*—as applied to a solid or semi-

solid—I think not only of a tendency to resist a deforming stress, but also that after the deforming stress is removed, the elastic tissue, semi-solid, or solid will return to its original shape.

Our bodies' visco-elastic soft tissue is a lot like the meat on a butcher block and cold tar or asphalt. They all "creep" in response to a deforming stress. And when the stress is removed they tend to return to their original shape.

These views of *visco-elastic* may be too simple. I invite further comment about this matter from physicians.

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Treatment of 'Cafe Coronary'

Guest Editorial

NORMAN S. BLACKMAN, M.D.
Brooklyn, N.Y.

OK. What is it? It's not a coronary!

In 1963 Haugen coined the term "cafe coronary" to describe certain cases of sudden death in restaurants. Of 56 cases of death while eating, he found that while all had been attributed to heart attacks, 55 of them were actually the result of obstruction of the airway caused by food impaction. Only one was due to coronary artery disease.*

Choking while eating is often associated with attempts to ingest large pieces of food, excessive alcohol intake, ill-fitting or painful dentures and sometimes poor mastication of food and attempts to swallow large, unchewed portions whole, especially in edentulous patients.

Some years ago, a known cardiac patient of mine appeared in my office complaining of a peculiar sensation in his throat which started while he was eating lamb chops. While eating, he was concurrently engaged in a heated discussion concerning the intricacies of the gyrations of the stock market. He appeared neither in distress nor was he cyanotic. Without permitting me time to make a brilliant diagnosis, he coughed up a piece of lamb chop with a sizeable piece of bone attached—and promptly cured himself.

The author is editor of KCMS BULLETIN, published by the Medical Society of the County of Kings, Brooklyn. This editorial, reprinted with permission, appeared in the November 1979 issue.

An effective physician maneuver that can be easily applied to relieve choking due to mechanical obstruction by a foreign body in the airway is the result of the remarkable work of Dr. Henry J. Heimlich. The exact technique has been beautifully described and illustrated in a recent Ciba Clinical Symposia.* It should be required reading for all—physicians and non-physicians alike.

Personally, I feel that operations, maneuvers or procedures, etc., are best described in functional terms rather than by the names of their innovators. But the "Heimlich Maneuver" has been widely publicized and unquestionably has saved the lives of many choking victims. It is remarkable as an innovation in medicine since it appears to be a direct, simple, safe, widely applicable, effective and inexpensive treatment that can be applied to a specific life-threatening situation. Previously, little thought, research, experimentation or clinical guidance were available to the physician in this serious and not uncommon medical emergency.

In an era of highly sophisticated, expensive medical research protocols, researchers and equipment, it is refreshing to learn that some physicians still are concerned with devising simple, direct and easily applicable solutions to common life-threatening medical problems. Indeed, such research and experimentation might be a greater boon to mankind than result from the expenditure of many millions of dollars seemingly allocated randomly for investigation of highly selective, esoteric and rare medical conditions. Perhaps, research in simple, applicable solutions and techniques in clinical medicine might bring less reputation and notoriety to the innovator or researcher, but I believe it would be warmly welcomed by both patients and practicing physicians.

Right on, "Dr. Heimlichs" of the world, wherever you are!

*Ciba Clinical Symposia, 31:3, 1979.

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In today's world, what appears to be simple—for example, cutting health care costs—may turn out to be frustratingly complicated. Moreover, there may be unexpected consequences that harm the innocent victims of well-intentioned cost-cutting—often elderly men and women and the disabled, those who are most vulnerable and most helpless.

An illustration of what can happen—what *did* happen, in one instance—is provided in a new, pioneering study of one state's earnest effort to reduce health care costs.

The state dropped a large number of medicines from the list of drugs it would pay for under the Medicaid program, assuming that this step would save money.

As a result, Medicaid's prescription drug payments did drop by 11.4 per cent.

But more Medicaid patients had to go into hospitals, and they stayed there longer—and hospitalization costs a lot more than medicines.

So instead of saving money, the government spent more money.

The net result was that, although spending for prescription medicines dropped \$4.1 million, spending for the total Medicaid program went up by \$15.1 million.

Furthermore, most of those who had to be hospitalized were elderly men and women (covered by Medicaid's Old Age Assistance program) or the handicapped (covered by the Aid to the Disabled program). Thus, it can reasonably be assumed that quite a few older people and disabled men and women who might otherwise have been able to live relatively independent lives in the community became so sick that they had to go into the hospital.

Patients, Regulation, and Health Care

It began as an honest attempt to lower health care costs in Louisiana.

The idea was to cut down on the number of drugs the state would pay for under Medicaid.

It worked.

But the costs for hospitalization skyrocketed!

The Human Toll

It must be borne in mind that the only thing the study measured was the cost in dollars. The cost of human pain, distress, lives disrupted by hospitalization, and other consequences is probably immeasurable, but it does not take a lot of imag-

ination to figure out how great that cost must have been.

This is a story without villains. Everyone involved tried to do the best he or she could for the public good. But matters didn't turn out quite the way anyone expected.

It happened in Louisiana, in 1976. Members of the state Legislature, under pressure from the taxpayers to hold down the rising costs of government, voted fewer funds to the Medicaid program than the state health authorities expected the program to cost. The Louisiana Health and Human Resources Administration pleaded for more money, but was turned down.

Therefore, the state health authorities, under the pressure of a very short deadline, took the only step that seemed to permit an immediate cut in spending. They announced that, effective August 1, 1976, Medicaid in Louisiana would no longer pay for certain kinds of medicines. The medicines they decided to drop from the Medicaid program were appetite-depressants, cough and cold preparations, minor tranquilizers, most medicines for treating anemia, certain drugs used in the treatment of digestive disorders, a great many vitamins, and a number of miscellaneous products, such as an enzyme (a natural protein) that reduces inflammation, eliminates excessive fluid, eases pain, and speeds the healing process.

The state did not deny that people might need these medicines. And there was no suggestion that any of these drugs had been overprescribed or otherwise abused. When the state drew up its Medicaid cuts, it wasn't trying to correct drug abuse—it was simply, and understandably, trying to save money.

What the state health authorities did made sense to them at the time. By eliminating the specified medicines, they estimated, the total

Medicaid drug budget could be cut by 15.68 per cent, for a saving of \$5.6 million.

Studying the Effects

But, as progressive public officials, they wanted to get an impartial judgment of just how well the the budget cuts worked. So they cooperated wholeheartedly with Dennis L. Hefner, Ph.D., professor of economics at California State University, Chico, California, in a study he carried out. He was assisted in the study by Pracon, Inc., a well-known research firm.

Financed by a grant from the National Pharmaceutical Council, Pracon's staff specialists worked under the direction of Donald R. Roden. They developed the data base, directed the data processing, managed the analytical activities, and provided administrative services.

Restrictive formularies (the term used when certain medicines are dropped from a program) have been put into effect in other places at various times, but there had always been other factors complicating the picture, so it was impossible to pinpoint exactly what had happened. But in Louisiana in 1976 the restrictive formulary was the only change made in the Medicaid program; so Dr. Hefner regarded the situation there as a unique opportunity to evaluate the formulary's overall impact.

There were no other factors (such as an epidemic) to confuse the issue during the period under study. In addition, the state authorities said they were willing to help in the collection of computerized health information.

The periods covered by the study were the six months before the Medicaid change was made (February 1, 1976, to July 31, 1976) and the same six months of the following year.



With the aid of official records, a sample of 10,482 patient records for the 1976 sample period was assembled, along with the same number for 1977. Although individual identities were concealed by codes to protect each patient's right of privacy, the people in the 1977 sample were selected to match exactly the age, sex, race, residence (urban and rural), and Medicaid category of the same number of patients in the 1976 sample.

Significant Findings

The findings were indeed significant—for example:

- As intended, the spending for prescriptions dropped by 11.4 per cent.
- Among the families with dependent children, there was a slight increase in hospitalizations, a big increase in nursing home stays, and a decline in physician visits. (The study covered only a relatively short period of time; therefore, it could not measure the possible future effect of cutting back on vitamins for the children in the program.)
- Among the elderly, covered by the Old Age Assistance program, and the handicapped, covered by the Aid to the Disabled program (the two programs were treated as one in the study, for technical reasons), the Medicaid cutback had the biggest impact. Hospitalization days more than doubled, and those who were hospitalized had to stay in the hospital longer. The number of physician visits also increased significantly.

Relative Costs

In considering these findings, it is important to bear the relative costs in mind. On a national scale, in 1977—

- A day in the hospital cost an average of\$173.98
- A physician visit cost an average of\$ 25.73
- A prescription cost an average of\$ 5.25

Why did more Louisiana Medicaid patients have to go into hospitals or nursing homes after the specified medicines were dropped from the program?

That is not covered by the report. But it isn't hard to figure out what happened.

Let's consider one type of patient—an elderly person who suffers from high blood pressure. It is not uncommon, in such cases, for a doctor to prescribe a mild tran-

quilizer in order to counter the effects of everyday stress on the patient. Without such medication, the blood pressure problem may get worse, requiring hospitalization.

The Louisiana study found that patients suffering from nervous system disorders were most likely to be adversely affected by the Medicaid cutback, with heart patients a close second. People who had problems with their circulatory systems, their digestive tracts, or anemia were also fairly likely to require hospitalization because their medicines had been eliminated from the program.

The conclusions of Dr. Hefner: —“(The findings) strongly suggest that the Louisiana restricted formulary . . . had an adverse impact on the health status of

the Medicaid population.” —“(It) increased the associated costs for non-prescription services.”

It might also be said that the findings indicate how important prescription medicines are in keeping people well and active.

No Easy Ways to Save

The Louisiana study should be important to Americans in every state. For every state is trying to find ways to cut the cost of health care. Private insurers are trying to reduce their spending, too.

Moreover, a national debate has been going on for several years about the possible establishment of some kind of National Health Insurance program—and about how to keep the costs down, if indeed such

a program is ever enacted by Congress.

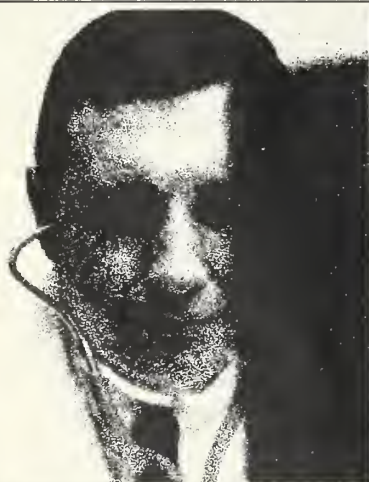
If a restricted formulary should be applied to such a program, the result could be greater cost, rather than less cost.

The Louisiana experience tells us that there are no easy ways to save money on health care costs.

If we do not consider all the possible effects of our cost-cutting proposals, we may end up spending more in the final analysis.

We may also, inadvertently, harm the health of those who are particularly vulnerable to disease and disability—our senior citizens.

Above all, the Louisiana study is a reminder that prescription medicines are our cheapest, and often our most effective, way of treating the sick.



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CLINICAL NOTES

Fragrance Sensitivity

A patient recently remarked "Doctor, a woman just doesn't feel like a woman without perfume. Can't something be done about this (allergy)?"

Successful treatment of fragrance dermatitis requires strict avoidance of the problem component. Unfortunately, the ingredients are neither on the label nor available from the manufacturer. Perfumes are also virtually impossible to totally avoid. They are found in soaps, cosmetics, toiletries, and, in fact, almost all household products. Chemically related flavors also may cause problems in fragrance-sensitive persons.

An informal survey in my office indicates sensitivity to perfumes may be far more common than is generally realized. Many individuals never seek medical help since they discover the cause on their own and avoid products that cause a reaction. Such an empirical approach can be both expensive and frustrating.

The cause of photocontact dermatitis to many colognes has previously been an enigma but some, at least, are due to musk ambrette.¹ This ingredient is so important in the industry that a perfumer hardly works a day without using it.² Higher concentrations have been employed in recent years,² however, which possibly may explain the newly described photosensitivity.

It has been claimed perfumes comprise too many items for convenient labeling, but a package insert would solve that problem. Cosmetic ingredients currently are required on the label but fragrances are exempt. Perfume-sensitive patients can only hope Congress soon will see fit to change this.

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Patch Testing

The patch test has undergone remarkably little change since its inception, but there are a few new developments. Patch testing may be done either open or closed. The latter method employs a cover following application of the suspected ingredient in the proper vehicle and concentration. Several sources of such information are available.^{1,2}

The use of a recessed aluminum disc held in place by Scanpore® tape as described by Pirilä³ is a noteworthy advance over the use of adhesive plaster. Scanpore® tape is nonirritating, hypoallergenic and has remarkable adhesive qualities. This tape dependably holds patches in place even in small children. The small aluminum "chamber" allows the application of multiple patches in a small area. The disc provides tight occlusion while minimizing the size of the skin reaction. A recently proposed modification promises delivery of an even greater concentration of test agent per unit area.⁴ That chamber, however, is not yet available.

There is no perfect time for reading patch tests. The best overall procedure is to remove patches at 48 hours and to read them at 72 hours. However, some tests are positive if left on only 24 hours and negative when occluded 48 hours, and vice versa.⁵ It is desirable but not always practical to do additional readings at four and five days. Some allergic reactions cannot be found unless this is done.

One should avoid patch testing with unknown materials, unknown concentrations, higher concentrations than acceptable, and known irritants. It also is prudent to withhold patch testing until the eruption has subsided, as a positive test can flare the original condition. However, one is sometimes forced to do early patch testing to find and remove a not-so-obvious cause.

Contrary to popular opinion, a positive reaction to a substance does not *prove* it caused the original condition. False negative results also can occur for a variety of reasons. All of this makes life interesting for those of us who must manage patients with contact dermatitis.

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Maternal Deaths in Indiana Due to Hemorrhage: 1959-1977

WILLIAM D. RAGAN, M.D.¹
JOHN L. DENTON, M.D.²
Indianapolis

THE INDIANA MATERNAL Mortality Committee was established in 1955 with the objective of reducing the maternal mortality rate in the state. Over the period 1959-1977 the maternal mortality rate has decreased from 33.9 per 100,000 births in the years 1959-1963 to 12.4 in the years 1974-1977.

Deaths due to maternal hemorrhage accounted for 29.4% of all deaths during the 1959-1977 period. It is the purpose of this report to analyze the data from this committee as to maternal deaths related to hemorrhage.

PROCEDURE

The Maternal Mortality Committee is composed of obstetricians and specialists in anesthesiology, cardiology, general practice, internal medicine, pathology and urology. Death certificates are screened by the State Board of Health for obstetrical complications and referred to the committee. In each case, the committee sends a consultant who

interviews the physician, reviews the hospital record, and contacts the pathologist and any other consultants who might have become involved in the case. The consultant prepares a summary for the committee. The committee reviews each case to determine the cause of death.

EXPLANATIONS

The data in this study are drawn from cumulative records kept by the committee.

Results: *Table 1* summarizes the percentage of maternal deaths due to hemorrhage. *Table 2* shows the percentage of deaths due to hemor-

TABLE 1
Percentage of Deaths Due to Hemorrhage: 1959-1977

Year	Births	Maternal Deaths	Deaths Due To Hemorrhage	Percentage of Deaths Due To Hemorrhage
59	114,239	34	15	41.1
60	114,281	34	8	23.5
61	113,768	41	11	26.8
62	110,277	47	13	27.7
63	108,403	35	5	14.3
64	107,443	33	12	36.4
65	99,345	33	8	24.2
66	96,939	22	4	18.2
67	94,835	29	8	27.6
68	92,725	20	6	30.0
69	95,015	14	1	7.1
70	100,624	10	6	60.0
71	96,666	28	9	32.1
72	88,230	9	4	44.4
73	84,827	15	3	20.0
74	89,184	13	6	46.1
75	83,258	8	4	50.0
76	81,428	13	6	46.2
77*	83,000	8	2	25.0

*Estimated Number of Births

¹Chairman, Indiana Maternal Mortality Committee, Indiana University Medical Center, Indianapolis.

²Chief Resident Physician, Obstetrics and Gynecology, Indiana University Medical Center, Indianapolis

TABLE 2
Percentage of Deaths Due to Hemorrhage in 5-Year Periods

Year	No. of Maternal Deaths	Deaths Due To Hemorrhage	Percentage of Deaths Due To Hemorrhage
59-63	191	52	27.2
64-68	137	38	27.7
69-73	76	23	30.3
74-77	42	18	42.8
Totals:	446	131	29.4%

rhage divided into five-year periods—1959-1963, 1964-1968, 1969-1973 and 1974-1977.

Tables 3 and 4 compare the various causes of hemorrhage—related deaths and the percentage due to each cause during each year. The causes are listed under the following categories: ectopic pregnancy, uterine rupture, post partum atony, abruption, retained fragments of placenta, coagulation defects, abortion (both spontaneous and elective), placenta previa, post operative bleeding and cases where

the etiology could not be determined.

Tables 5 and 6 are comparisons of the various causes of maternal deaths due to hemorrhage divided into five-year periods—1959-1963, 1964-1968, 1969-1973 and 1974-1977. Table 7 is a listing of the various causes of deaths associated with uterine rupture.

DISCUSSION,

CASE REPORTS

There were 446 maternal deaths in Indiana from 1959-1977; 131

died of hemorrhage. The percentage of maternal deaths related to hemorrhage was 29.4% over the study period. The percentage of maternal deaths related to hemorrhage has been increasing over the study period. In the years 1959-1963 the percentage was 27.2%. In the years 1974-1977 the percentage rose to 42.8%.

● Deaths due to *ectopic pregnancy* accounted for 40 of the 131 deaths due to hemorrhage, or 30.5%. This percentage has remained constant over the study period, accounting for 30.8% of the hemorrhage-related deaths in the years 1959-1963, 26.3% in the years 1964-1968, 34.8% in the years 1969-1973 and 33.3% in the years 1974-1977. Apparently, ectopic pregnancy remains a diagnostic enigma. All of these deaths were judged by the committee to be preventable.

Approximately one-third of the cases were DOAs (dead on arrival).

TABLE 3
Causes of Death Due to Maternal Hemorrhage

Year	No. Deaths Due to Hemorrhage	Ectopic Preg.	Uterine Rupture	Postpartum Atony	Abruptio	Retained Fragments	Coagulation Defects	Abortion Related	Placenta Previa	Post-Operative Bleeding	Etiology Unknown
59	15	4	5	0	0	0	1	1	2	1	1
60	8	1	3	1	1	1	0	0	1	0	0
61	11	4	3	0	1	0	1	0	0	1	1
62	13	5	3	1	2	1	0	0	1	0	0
63	5	2	2	0	0	0	0	1	0	0	0
64	12	3	2	1	0	2	1	2	0	0	1
65	8	3	1	2	1	0	0	1	0	0	0
66	4	1	1	0	1	0	0	0	1	0	0
67	8	2	2	2	0	0	1	0	1	0	0
68	6	1	1	2	2	0	0	0	0	0	0
69	1	1	0	0	0	0	0	0	0	0	0
70	6	2	2	0	1	0	0	1	0	0	0
71	9	3	5	0	0	0	1	0	0	0	0
72	4	1	2	1	0	0	0	0	0	0	0
73	3	1	1	1	0	0	0	0	0	0	0
74	6	3	2	0	0	0	1	0	0	0	0
75	4	1	1	1	0	0	0	0	0	0	1
76	6	2	0	1	0	2	0	1	0	0	0
77	2	0	0	0	0	1	1	0	0	0	0
TOTALS	131	40	36	13	9	7	7	7	6	2	4

TABLE 4
Percentage of Each Cause of Death Due to Maternal Hemorrhage

Year	No. Deaths Due to Hemorrhage	Ectopic Preg.	Uterine Rupture	Postpartum Atony	Abruption	Retained Fragments	Coagu- lation Defects	Abortion Related	Placenta Previa	Post- Operative Bleeding	Etiology Un- known
59	15	26.7	33.3	0	0	0	6.7	6.7	13.3	6.7	6.7
60	8	12.5	37.5	12.5	12.5	12.5	0	0	12.5	0	0
61	11	36.4	27.8	0	9.1	0	9.1	0	0	9.1	9.1
62	13	38.5	23.0	7.7	15.3	7.7	0	0	7.7	0	0
63	5	40.0	40	0	0	0	0	20.0	0	0	0
64	12	25.0	16.7	8.3	0	16.7	8.3	16.7	0	0	8.3
65	8	37.5	12.5	25.0	12.5	0	0	12.5	0	0	0
66	4	25.0	25.0	0	25.0	0	0	0	25.0	0	0
67	8	25.0	25.0	25.0	0	0	12.5	0	12.5	0	0
68	6	16.7	16.7	33.3	33.3	0	0	0	0	0	0
69	1	100	0	0	0	0	0	0	0	0	0
70	6	33.3	33.3	0	16.7	0	0	16.7	0	0	0
71	9	33.3	55.6	0	0	0	11.1	0	0	0	0
72	4	25.0	50.0	25.0	0	0	0	0	0	0	0
73	3	33.3	33.3	33.3	0	0	0	0	0	0	0
74	6	50.0	33.3	0	0	0	16.7	0	0	0	0
75	4	25.0	25.0	25.0	0	0	0	0	0	0	33.0
76	6	33.0	0	16.7	0	16.7	0	16.7	0	0	0
77	2	0	0	0	0	50.0	50.0	0	0	0	0

Factors Involved Were: Inadequate evaluation of the patient's complaints; undiagnosed and released; delayed surgical intervention; insufficient blood replacement; patient's ignorance; negligence.

Case Summary: 23-year-old gravida 1, para 0, with one missed menses. Spotting. Seen in emergency room with lower abdominal pain and vomiting. Not examined. Given Demerol and released. Told to call if not better. Called the next morn-

ing, but died by the time the doctor got to the house. Autopsy showed ruptured right tubal pregnancy.

● The second leading cause of hemorrhage was *rupture of the uterus*. There were 36 cases or 27.5% of the 131 hemorrhage-related deaths associated with uterine rupture. Again, this percentage has remained fairly constant over the study period. Seventeen of these cases were related to trauma, 12 were due to improper use of oxytocin, six were related to previous cesarean section in labor,

and one case occurred spontaneously in a mother in active labor. All of these cases were judged to be preventable.

Factors Involved Were: Version-extraction; high forceps; difficult midforceps; failed forceps; shoulder dystocia; cephalopelvic disproportion; delivery of breech through an incompletely dilated cervix; Dührssen's incisions; prolonged labor; IM oxytocic; inadequate supervision with oxytocic stimulation of labor; lack of blood bank facilities.

TABLE 5
Causes of Maternal Deaths Due to Hemorrhage in 5-Year Periods

Years	No. of Deaths	Ectopic Preg.	Uterine Rupture	Postpartum Atony	Abruption	Retained Fragments	Coagulation Defects	Abortion Related	Placenta Previa	Post-op Bleeding	Etiology Unknown
59-63	52	16	16	2	4	2	2	2	4	2	2
64-68	38	10	7	7	4	2	2	3	2	0	1
69-73	23	8	10	2	1	0	1	1	0	0	0
74-77	18	6	3	2	0	3	2	1	0	0	1
Totals:	131	40	36	13	9	7	7	7	6	2	4

TABLE 6
Percentage of Various Causes of Maternal Deaths
Due to Hemorrhage in 5-Year Periods

Years	Ectopic Preg.	Uterine Rupture	Post- partum Atony	Abruption	Retained Fragments	Coagulation Defects	Abortion Related	Placenta Previa	Post- Operative Bleeding	Etiology Unknown
59-63	30.8	30.8	3.9	7.7	3.9	3.9	3.9	7.7	3.9	3.9
64-68	26.3	18.4	18.4	10.5	5.3	5.3	7.9	5.3	0	0
69-73	34.8	43.5	8.7	4.3	0	4.3	4.3	0	0	0
74-77	33.3	16.7	11.1	0	16.7	11.0	5.6	0	0	5.6
Totals:	30.5	27.5	9.9	6.9	5.3	5.3	5.3	4.6	1.5	3.1

Case Summary: 36-year-old gravida 11, para 9 at term. X-ray showed double footling breech. No FHTs. Taken to delivery room with cervix 4-6 cms. Attempt to deliver. Both fetal legs pulled off. Patient went into shock and died. Autopsy showed tear extending from the cervix up into the uterus.

● *Post partum atony* was the cause of 13 of the 131 cases of maternal deaths due to hemorrhage. This represents 9.99% of these cases.

Factors Involved Were: Uterine packing; inadequate observation after delivery; uterine atony inadequately handled; anemia prior to delivery; underestimated blood loss; insufficient blood replacement; inadequate blood bank facilities.

Case Summary: 40-year-old gravida 8, para 7. Admitted with diagnosis of intrauterine fetal death times four days, term, for induction of labor. This was carried out with amniotomy and IM oxytocic with no effect. Spontaneous labor started a day later. Delivered a 10 lb. 4 oz. macerated infant. Placenta was expelled intact. Apparently stable in recovery room. Two and one-half hours after delivery, was found in shock on the ward with heavy vaginal bleeding and large clots. Doctor was unable to start an in-

travenous. Patient died while a cut-down was being attempted.

● *Premature separation of the placenta* accounted for nine or 6.9% of the cases in the study. The frequency of abruption as a cause of maternal death is decreasing with only one case in the last nine years of study.

Factors Involved Were: Delay in diagnosis and proper treatment; insufficient blood replacement.

Case Summary: 38-year-old gravida 7, para 6, near term. Admitted to hospital with bright red bleeding. No FHTs. BP was 210/150. No contractions. Magnesium Sulfate and Demerol. Patient went into shock three hours after admission with profuse bleeding. Blood was started and membranes ruptured. Contractions began. Delivered a 5 lb. 9 oz. stillborn. Placenta delivered after infant with large clots. No BP obtained. Patient died.

● There were seven cases of death due to *retention of placental fragments*. This accounted for 5.3% of the cases in the study.

Factors Involved Were: Delayed and missed diagnosis.

Case Summary: A typical case was a 22-year-old gravida 2, para 1

white woman with normal labor. Delivered a 7 lb. 2 oz. infant without difficulty. Two hours after delivery she began to bleed heavily. Patient was treated with IM Pitocin and Ergotrate. Bleeding continued and the patient went into shock. The patient died as she was being taken to O.R. for curettage. Fragments of placenta were found in the uterus at the time of autopsy.

● There were seven cases of deaths due to *coagulation defects* in the study. This accounted for 5.3% of the cases in the study. The frequency of maternal deaths due to coagulation defects seems to be increasing from 3.9% in 1959-1963 to 11.0% in 1974-1977.

Factors Involved Were: Lack of promptness in making the diagnosis; poor judgment; delay in instituting treatment; inadequate management.

Case Summary: 27-year-old gravida 7, para 6. Term, early labor, no fetal heart tones. Patient was uncomfortable. Strong contractions lasting four minutes. Cervix 1 cm. Demerol and Phenergan. Started bleeding shortly after admission. Was given one unit of whole blood. Sterile vaginal exam revealed no previa. Membranes were artificially ruptured and cervix manually dilated to 7 cms. Delivered a stillborn infant. Placenta

expelled two minutes after delivery with profuse bleeding. Patient continued to bleed in spite of IM Pitocin and Ergotrate. Blood on floor did not clot. OB consultation obtained. IV Pitocin drip and IV Premarin. Exploration of the uterus showed no laceration. Given another unit of blood and one unit of fibrinogen. Patient died. Fibrinogen after first unit of blood was 50 mgm. %.

- There were seven cases related to spontaneous, elective and criminal abortion. These accounted for 5.3% of the deaths in the study.

Case Summary: 22-year-old G2 P1 at eight weeks had sudden onset of profuse vaginal bleeding following intercourse. The patient was taken to the hospital where she was DOA. Pathology report showed there were products of conception in the uterus and no evidence of emboli in the lungs.

- There were six cases, or 4.6%, related to *placenta previa*.

Factors Involved Were: Failure to make proper diagnosis; improper examinations; failure to administer adequate blood replacement.

Case Summary: 34-year-old gravida 5, para 4, near term. Rectal exam in office revealed boggy mass. No bleeding. Later in the evening the patient had profuse bleeding. Shock upon arrival at the hospital. Was given blood. Sterile exam revealed central previa. Patient died on the way to surgery.

- There were two cases of deaths related to *post operative bleeding*.

Case Summary: 27-year-old gravida 5, para 4. Admitted at 42 weeks gestation because of an 8 lb. weight gain in one week. BP was normal. Pap smear had shown atypical cells. Because of this, plus

Cause of Rupture	No. of Cases	Percentage
Traumatic	17	47.2%
Use of Oxytocin	12	33.3%
Previous C-Section	6	16.7%
Spontaneous	1	2.8%

a desire for sterilization, two weeks past EDC and pre-eclampsia, a consulting obstetrician recommended cesarean hysterectomy, removal of cervical stump, appendectomy and umbilical hernial repair. 500 ccs. of whole blood was given during surgery. Two more units were given the following day because of difficulty in maintaining blood pressure. Intra-peritoneal aspiration yielded non-clotting blood.

The patient was returned to surgery on the second postoperative day. A large hematoma was evacuated intra-abdominally and the left uterine artery re-ligated. Four units of blood were given during surgery and one more day after. Intake and output record showed patient had far more fluid intake than output. She subsequently developed congestive heart failure and succumbed. Surgical pathology report revealed carcinoma *in situ* of the cervix. No autopsy was obtained.

- There were four cases in which there was *inadequate data* to determine the cause of the hemorrhage.

SUMMARY

There has been a decrease in the maternal mortality rate over the study period of 1959-1977. The leading causes of maternal death in Indiana are: 1) Hemorrhage—131 cases, 2) Infection—74 cases, 3) Embolic phenomena—63 cases, and 4) toxemia—61 cases.

Hemorrhage remains the primary cause of maternal death in Indiana.

29.4% of all maternal deaths in the study period were due to hemorrhage. While the relative percentages of deaths due to infection and embolic phenomena are decreasing or stable, the rate of deaths due to maternal hemorrhage increased to 42.8% in the years 1974-1977.

The major causes of deaths due to hemorrhage are: 1) Ectopic pregnancy—40 cases, 2) Uterine rupture—36 cases, 3) Atony—13 cases, 4) Abruptio—9 cases, 5) Retained placental fragments, coagulation defects and abortion related deaths (each caused with 7 cases), 6) Placenta previa—6 cases, and 7) Post operative bleeding—2 cases. There were no major trends in the relative percentages of these causes of maternal death due to hemorrhage.

In recent years maternal death secondary to maternal trauma and subsequent uterine rupture has decreased. In Indiana the leading cause of maternal mortality is ruptured ectopic pregnancy. Through the years its incidence has remained the same. This condition apparently remains a diagnostic enigma. All physicians that treat women in the reproductive years must be alert to this condition.

It is hoped that this report will point out that still more improvement can be made with regard to a leading cause of maternal death—hemorrhage. It is the contention of the authors that practically all maternal deaths due to hemorrhage are preventable, or have preventable factors involved.

Constrictive Pericarditis After Valve Replacement*

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CONSTRICTIVE PERICARDITIS may occur as a result of infection by a virus, tuberculosis or a pyogenic organism. Other causes include trauma and malignancy. This patient developed constrictive pericarditis years after mitral valve replacement.

CASE PRESENTATION

This 37-year-old woman, who had rheumatic fever as a child, had a closed mitral commissurotomy in 1960, at age 19. She did well for approximately five years. Her symptoms returned and in 1969, at age 28, she had an open commissurotomy. Following surgery, relief of symptoms lasted approximately a year. Her return of symptoms was precipitous and she required urgent mitral valve replacement in 1970. A Starr Edwards composite seat M. 1 valve was placed.

The patient did fairly well until approximately two years prior to her current admission when she developed dyspnea on exertion, palpitations, ascites, peripheral edema and finally episodes of syncope. She was admitted to Community Hospital, Indianapolis, Ind., in

April 1978. After appropriate work-up, cardiac catheterization was performed by Richard Linback, M.D. No gradients were found across any of her cardiac valves at rest or during exercise. The diastolic pressures were uniformly elevated in all chambers (from 21 to 25 mm. Hg.). The left ventricular contractility was excellent.

She was transferred to Methodist Hospital and treated medically. On one occasion, after admission, she suffered ventricular tachycardia and respiratory arrest. We became convinced that constrictive pericarditis was the cause of her symptoms. A pericardiectomy was done through an anterior bilateral thoracotomy. She recovered and was able to go home approximately two weeks postoperatively.

Since surgery, the patient has experienced relief from her shortness of breath, peripheral edema, ascites and syncope. She still is bothered occasionally by palpitations, but functionally is much improved.

DISCUSSION

Constrictive pericarditis is known to occur after chest trauma due to secondarily retained blood in the pericardial space.¹ One might expect that late constrictive pericarditis, after open heart surgery, would not be unusual; but, in fact, it is quite rare. In 1976, Simon² reported a patient who became symptomatic six weeks after double

valve replacement and died 12 weeks after surgery from constrictive pericarditis. At that time there was not another reported case of constrictive pericarditis after open heart surgery, in a patient who had had valve replacement without sepsis.

Reports of cardiac tamponade after open heart surgery, associated with the use of anticoagulants, are not uncommon.³ Pericardial constriction with⁴ and without⁵ large pericardial hematomas are rarely reported. With the increased use of aortocoronary bypass operation for arteriosclerotic heart disease, constrictive pericarditis as a possible cause of cardiac symptoms in the postoperative period must be kept in mind.

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*Aided in part by a grant from The Showalter Fund.

Pressure Increases Due to Squeezing the Barium Enema Bag

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SEVERAL YEARS AGO a lawyer asked me, "What are the pressures in the colon when the barium enema bag is squeezed, Doctor?"

"I don't know," I told him.

I still don't know exactly, but after some measurements some statements and an approximation can be made.

My original work on the measurement of intracolonic pressure during barium enema examinations was done at the Indiana University Medical Center in the early 1960s. At that time, in most places, the metal can supported at a set height was the source of the barium enema. It provided a stable minimum head of hydrostatic pressure that couldn't be squeezed. There was a varying height of liquid in the can, from 0 to 20 cm above the bottom of the can usually. Since the uppermost height of the colon being filled usually varied from 10 to 20 cm above the tabletop, the height of the bottom of the enema

can above the tabletop could be taken to approximate the head of hydrostatic pressure available in the system.

But nowadays most radiologists use the disposable barium enema bags; they are about 45 cm long at most when they are filled with liquid, and if one adds about 25 cm to the height previously used for the barium enema can, he can approximate the maximum hydrostatic pressure this system can create for the long, sausage-shaped bags—if the bags aren't squeezed.

But squeezing the barium enema bag is often done, by different people, with different strengths, using different techniques. It seems that the variation in squeezing the barium enema bag may be infinite.

To get some approximations, in order to answer the question, "What are the pressures in a closed system when the barium enema bag is squeezed," a young woman x-ray technologist of average strength, age 25 years, body mass of 66 kilograms and a height of 163 cm, squeezed the bag in three different ways, 10 times each way, with the increased pressure in a rigid system, measured each of the 10 times. Then a middle-aged radiologist of average strength, age 46 years,

body mass of 99 kilograms and a height of 180 cm, squeezed the enema bag two ways; one of the two ways was a tight squeeze with one hand, as done by the woman technologist during one of her methods. Ten trials for each method were done with the tightly closed system, and the pressures also recorded.

Method 1: PJ squeezed the enema bag between her right thumb and long finger; the thumb was 12 cm above the bottom of the bag. Increases in pressure ranged from 8 to 54 mm Hg. in this closed system. The changes in pressure took place in about 0.3 seconds.

Method 2: PJ squeezed the enema bag by tightly squeezing it between her right thumb and all of her right fingers; the thumb was 12 cm above the bottom of the bag. The increases in pressure ranged from 34 to 62 mm Hg in this closed system. The changes in pressure took place in about 0.3 seconds.

Method 3: PJ squeezed the enema bag tightly between all right fingers and her right thumb; her thumb was 31.5 cm above the bottom of the bag. The increases in

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Method 1



Method 2



Method 3



Method 4



Method 5

pressure in this tightly closed system ranged from 40 to 90 mm Hg. The changes in pressure took place in about 0.25 seconds.

Method 4: RJN squeezed the enema bag tightly between all the right fingers and his right thumb; the thumb was 12 cm above the bottom of the bag. The pressure increases in this tightly closed system ranged from 122 to 132 mm Hg. This was the same method used by PJ in Method 2; the marked increase in pressures when Method 4 is compared with Method 2 is probably due to comparing a man's strength with a woman's. The changes in pressure took place in about 0.9 seconds.

Method 5: RJN squeezed the enema bag tightly by wringing it between both hands. One thumb was 12 cm above the bottom of the bag; the other thumb was at 22 cm above the bottom of the bag. The pressure increases in this tightly closed system ranged from 124 to 290 mm Hg. The changes in pressure took place in about 1.1 seconds.

It should not be presumed that these closed system pressure increases are the pressures that would always occur within the lumen of the colon during a barium enema examination. With barium advancing in the colon, the colon is not a closed system, and it takes a large change in volume to affect the pressure. Most of the hydrostatic pressure from the enema bag (squeezed or not squeezed) is changed to kinetic energy and is used to advance the column of barium in the colon, if there is no obstruction.

If there is obstruction present, but tone also is present—as indicated by haustra—squeezing on the enema bag would cause some increase in intraluminal pressure; I don't know how much. The colon walls would react to the increased surge of barium from the squeeze in a certain period of time; I don't know how long, and the increased intraluminal pressure would be less than in the manometer-tight rubber tube-enema bag system.

If there is obstruction, and no haustra are seen, the colon begins to approximate a metal pipe or a tight system, and an increased pres-

sure in the bag from squeezing it may cause the same pressure within the colon.

It is important to keep in mind that Burt¹ showed specimens of cecum perforating through both the muscularis and the mucosa at air pressures of 50 mm Hg (0.95 psi) and 60 mm Hg (1.14 psi).

I raise the enema bag occasionally when the flow is slow. I don't squeeze the enema bag or permit my technologists to squeeze it.

This work, with its limits and approximations, again points to the need for better measurements of intracolonic pressures. Measurements from a transducer in the colon, recorded by telemetry, are needed.

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Portal Hypertension

CASE 1

In December 1975 a 58-year-old man was treated medically for a second massive variceal bleeding documented by endoscopy.

With intensive medical management, the patient stopped bleeding and maintained good liver function. An end-to-side portacaval shunt was planned but could not be accomplished. A 10mm Dacron graft was interposed between the portal vein and vena cava. The patient did well and was released on the 10th day on a salt and protein restricted diet.

In June 1978 the patient was admitted with a massive GI hemorrhage documented by endoscopy as active variceal bleeding. Again the bleeding stopped with medical therapy. Angiographic studies demonstrated graft occlusion, and a mesocaval interposition graft was performed. Pre-shunt portal pressure was 310mm H²O; post-shunt was 180. The postoperative course was uneventful, and the patient was discharged 12 days later and has done well.

CASE 2

A 57-year-old woman had a second massive variceal bleeding in February 1979. After documentation of endoscopy, aggressive medical therapy was started, and the bleeding stopped. After careful evaluation, she was operated on. The portal vein was found to contain some thrombus. A mesocaval shunt was attempted but abandoned for lack of a suitable vein. The left renal vein was divided in the hilus of the kidney and anastomosed end-to-side to the splenic vein. Pre-shunt portal pressure was 340mm H²O; post-shunt was 190. The patient made an uneventful recovery.

Introduction

The subject of portal hypertension was discussed during the Peripheral Vascular Conference conducted in November 1979 at St. Vincent Hospital, Indianapolis. This report was prepared for THE JOURNAL by Austin L. Gardner, M.D., Indianapolis. Case presentation by John Wiggins, M.D.

DISCUSSION

Dr. Wiggins: Portal hypertension is essentially impedance of blood flow across the hepatic bed. Normal portal pressures are 120-150mm H²O. When pressures exceed 25-30cm, the problems of bleeding varices, ascites, encephalopathy and hypersplenism may become manifest.

What happens when a patient develops portal hypertension? With increased portal pressure, a hyperdynamic state develops. Tremendous flow of blood occurs, and the splanchnic bed becomes dilated. Peripheral resistance is lowered, and the cardiac index increases.

Charles Johnson, M.D.: What is the contribution of A-V shunting in the liver-to-portal flow?

Dr. Wiggins: The portal flow is tremendously increased.

Dr. Johnson: In cirrhosis, portal hypertension is not just a reflection of a damming of venous flow. There is an important contribution of A-V shunting from the hepatic arterial supply that increases portal flow.

John Isch, M.D.: As portal pressures increase, an obstruction to hepato pedal or antegrade portal flow occurs. Blood normally draining from the stomach and spleen through the splenic vein and through the coronary vein into the portal vein now goes retrograde and into the azygous system through esophageal collaterals. The esophageal veins that turn into varices are really collateral veins.

Dr. Wiggins: I would like to focus attention now on the role of surgical management. By far the most common indication for surgical intervention in portal hypertension is prevention of recurrent variceal bleeding. The literature has demonstrated that shunt procedures reduce the chance of recurrent variceal bleeding to as low as 12.5%. There is no indication for prophylactic shunt because, although the chance for bleeding is reduced, the incidence of encephalopathy is increased, up to 28%. Who then should be treated surgically?

Child's Classification

	GROUP A	GROUP B	GROUP C
Serum bilirubin (mg per 100 ml)	Below 2.0	2.0—3.0	Over 3.0
Serum albumin (gm per 100 ml)	Over 3.5	3.0—3.5	Under 3.0
Ascites	None	Easily controlled	Poorly controlled
Neurologic disorder	None	Minimal	Advanced "coma"
Nutrition	Excellent	Good	Poor, "wasting"

Dr. Johnson: Approximately 30% of patients with documented varices will bleed. A patient with documented bleeding has a 50% chance that this will occur the first year. The best treatment for an acute massive hemorrhage is intensive medical therapy with IV or intra-arterial pitressin and/or balloon tamponade following documentation of the site by endoscopy.

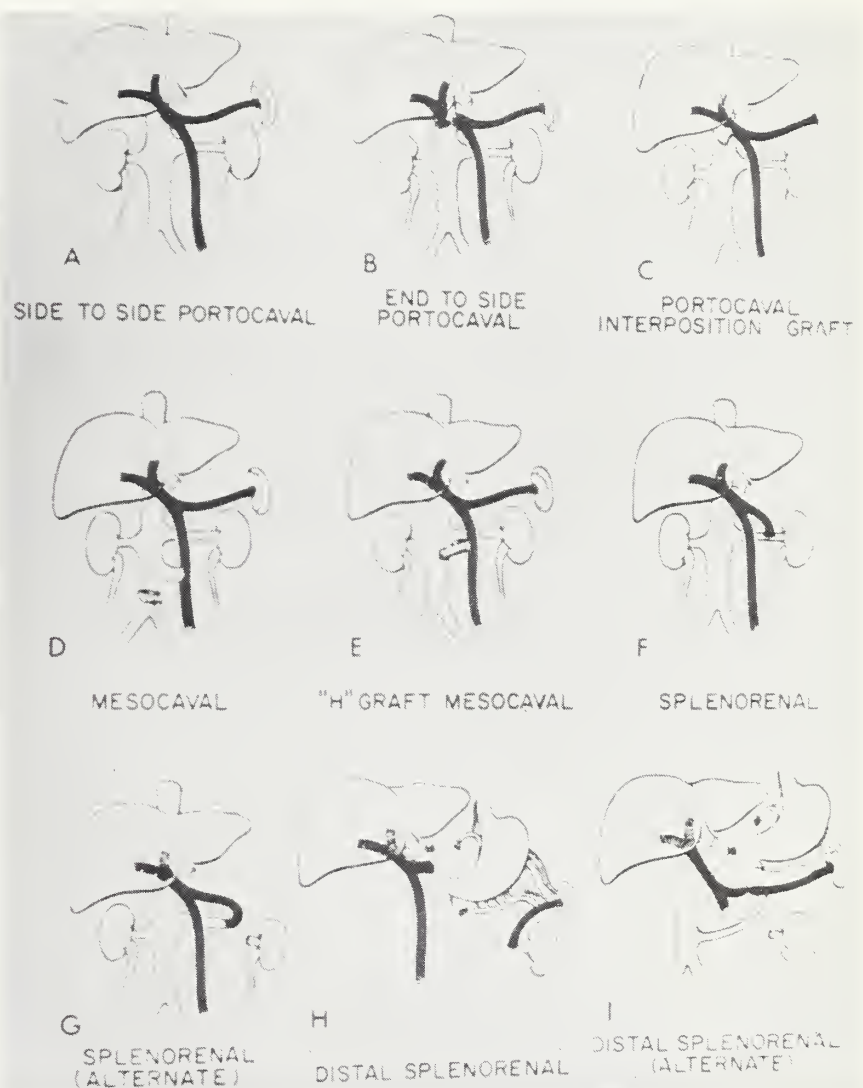
After the second variceal bleeding has occurred, the patient is considered a possible surgical candidate. The Child's classification is helpful as overall nutritional status, liver function and neurological status are considered. Ascites *per se* is not a contraindication.

It is the general consensus that emergency shunting procedures in poor risk, hemodynamically unstable patients are to be avoided where possible, as the operative mortality approaches 50%.

Dr. Isch: Surgical procedures used today include two basic categories: 1) Total portasystemic diversion with various modifications, and 2) portal-azygous disconnecting procedures and modifications.

With the end-to-side portacaval shunt, portal flow is totally diverted from the liver to the vena cava. Hepatic sinusoidal pressure is only slightly reduced. The procedure is excellent for control of bleeding, but post-shunt encephalopathy has been reported up to 28%. This is only a fair procedure for control of ascites.

The side-to-side portacaval shunt usually results in retrograde portal flow from the liver, thus allowing maximal decrease in hepatic sinusoidal pressure. This procedure is excellent for control of ascites. The rates of recurrent bleeding and post-shunt encephalopathy are about the same overall. Various modifications that behave physiologically as a side-to-side shunt include mesocaval, drapanas or inter-



Reprinted from *Surgical Clinics of North America*, April 1975.

position H graft and the classical splenorenal shunt.

The selective, distal splenorenal Warren shunt allows selective decompression and follows in part the portal-azygous disconnecting principle. The basic concept consists of a selective decompression of the esophagogastric-splenic venous area while maintaining portal perfusion by the superior mesenteric vein. Here hepatic sinusoidal pressure is either unchanged or mildly decreased. Post-shunt encephalopathy

has been reported in the range of 4-5%, and control of subsequent bleeding is good.

In summary, the choice of shunt procedure requires individualization and consideration of many technical factors. In a poor risk patient, a mesocaval interposition H graft is probably the fastest and easiest procedure. In a good risk patient with intact spleen, where technically possible, the Warren shunt is the procedure of choice.

Court Action

Health Systems Agency Must Exhaust Its Remedies

A Health Systems Agency (HSA) must exhaust its administrative remedies before seeking judicial review of a recommendation by a State Designated Planning Agency (DPA) to HEW that a hospital be reimbursed with federal funds for expenses related to a proposed capital expenditure, an Indiana appellate court has ruled.

A hospital applied to an HSA and a DPA for approval of a proposed purchase of a CT scanner. Approval by the DPA was necessary if the hospital was to be reimbursed for expenses related to the scanner under federal health programs. After a public hearing, the HSA recommended that the DPA disapprove the application. Nevertheless, the DPA approved the hospital's application and recommended that HEW reimburse the hospital if it purchased the scanner.

The HSA filed a petition for judicial review, alleging improprieties in the decision of the DPA. The trial court dismissed the petition, and the HSA appealed.

On appeal, the HSA contended that the National Health Planning and Resource Develop-

ment Act of 1974 provided that an HSA has a right of review.

The appellate court rejected the HSA's appeal. Assuming that the HSA is entitled to a review, the HSA had not exhausted its administrative remedies, the court said. The Health Planning Act requires that an HSA whose recommendation has been rejected by a state agency request a review by an agency of the state designated by the governor. The HSA did not make any request for such a review, the court found.

The HSA argued that exhaustion of administrative remedies is not necessary where it is doubtful that an administrative remedy is available. The HSA argued that no reviewing agency had been designated by the governor and, therefore, a request for review would be meaningless. The court stated, however, that it was not convinced a request for review would be futile.

A request for review might have prompted the governor to designate an agency, the court concluded in affirming the lower court's decision. —*Southern Indiana Health Systems Agency, Inc. v. State Board of Health*, 391 N.E.2d 845 (Ind. Ct. of App. Ct., July 10, 1979)

Courtesy of THE CITATION, Nov. 1, 1979.



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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. In bottles of 60, 250. Rx only.

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BOOK REVIEWS

Stop Forgetting

Dr. Bruno Furst. Revised and expanded by Lotte Furst and Gerrit Storm. Copyright 1979, Doubleday and Company, Inc., New York, N.Y. 10017. 340 pages, \$5.95.

Probably the most embarrassing fault of most people is the inability to remember. Regardless of our activity, the need of recall is presented to all of us practically every day and the lack of this faculty is often very uncomfortable, disconcerting and precipitates a state of self consciousness. Regardless of the area of work, society or sphere of action, we are repeatedly required to remember a name, a date, an event or facts which, if not in our memory and readily available, is often disappointing.

Dr. Furst has devoted over 30 years in research and study to determine how memory works and how it can be trained. While reviewing this publication, it is very obvious that it is the result of a trained mind; the various areas explored and the methods of procedures in developing an individual's recall is tremendous.

Memory by definition is the mental function or capacity of recalling or recognizing previously learned behavior or past experience. Memory is the basis of all knowledge. We know what we remember. It is an established fact that the average person forgets 80% of all the information he receives through all of his senses during a lifetime. The process of imprinting in the brain any subject or event depends upon the degree of interest the person has established, and the physiological sense memory rests on the pathway connecting our brain cells. In time, the process of forgetting proceeds more quickly than the process of learning. As always suggested, the aging of an individual decreases the ability to remember and the memory becomes less acute, but this has been disproven by the author. Senility is not, therefore, a natural cause of forgetfulness but is really the individual's lack of study or concentration in the area of activity and the resultant decrease in the memory.

Dr. Furst has endeavored to prove that to remember more effectively and to achieve your memory goals the various tests, as outlined in this book, if followed and effort made in the direction of adhering to the examples given, can become more efficient in establishing a much improved memory bank. This publication, as revised by the associates, is the most complete and comprehensive essay covering the subject of "stop forgetting" available today. The so called "system" will provide an individual with the keys to enhance and strengthen his ability to remember more effectively by simple tests and examples.

The degree of success depends upon the intensity

and concentration a person will exert in following the various outlines and exercises in the book. The overall improvement of the recall in all areas can be accomplished or, if desired, some specific techniques in the various professions and occupations are very thoroughly explained. The basic classifications can be remembered very simply. I was especially interested in the chapter on medicine and I intend to explore it and with the general information hope to improve my own state of forgetfulness.

I highly recommend this book to all my colleagues, because of the depth of the information, and the excellent manner of presentation. The general population will likewise benefit greatly if this publication is considered for the improvement of the faculty of forgetting.

IRVIN W. WILKENS, M.D.
Indianapolis
Internist

Handbook of Urological Endoscopy

J. G. Gow and H. H. Hopkins. Copyright 1978, Churchill-Livingstone, Edinburgh, London and New York. 89 pages.

There have been two major advances in endoscopic optics since 1954 and these are the invention of fibre-optics and the Hopkin's rod lens system for rigid endoscopes. The former allowed a central light source of high intensity while the new lens increased the field of view from 40° to 70°. Professor Hopkins was behind both of these advances and is an author of this book. Mr. Gow is a Liverpool (England) urologist.

The book is for the neophyte and consists of text and representative endoscopic photographs for illustration. Twelve chapters include the history of cystoscopy (by Professor D. M. Wallace, a distinguished British urologist), a treatise on applied optics by Professor Hopkins, and other pertinent practical considerations on sterilization, diathermy, and proper irrigating fluids. There are concluding sections on normal and pathological conditions of the bladder and urethra.

It is a curious volume because it is a potpourri of facts which seem to come to the authors' minds. For instance the life cycle of *Schistosoma haematobium* is included in the chapter of unusual bladder pathology. Nonetheless, I enjoyed reading it and felt it was very informative to me as a practicing urologist. Professor Hopkins has made great additions to the science of applied optics and it is good to know some of the underlying science involved in these advances.

All in all, recommended highly to urologists with a few chapters of interest to any endoscopist.

RODNEY A. MANNION, M.D.
LaPorte
Urological Surgery

Skin Deep: The Making of a Plastic Surgeon

Donald T. Moynihan, M.D. and Shirley Hartman. Copyright 1979, Little, Brown and Company, Boston 02106. 339 pages, \$10.

This book does not follow the usual type of publication in that it is not dealing with a review of some long standing research, new techniques or theories of upcoming procedures.

It is certainly not an "epic" in the field of medicine or a novel in drama but is a diary of a young surgeon in the field of plastic surgery and reveals the many episodes of training, experiences, trauma and accomplishments leading up to the establishment of his private practice.

The publication is easy to read and interest is maintained throughout because of the unique manner in which the author explores the various daily exposures in the performance of his duties as a resident in several hospitals. In a sense it reflects the life style I personally experienced during my training. I know this same opinion would be expressed by many physicians in all the various fields of medicine covering the medical school, the internship, the residencies and the eventual permanent placement.

Throughout the narration Dr. Moynihan brings out the routine procedures, unusual emergencies, unexpected complications and his own personal tragedy, which could have been very discouraging had it not been for his own devotion and determination to reach his goal.

This is not a medical text but is directed basically toward the general public for an insight into the workings of the staff of any hospital. I can recommend this book for a night's reading and the associated relaxation and enjoyment.

IRVIN W. WILKENS, M.D.
Indianapolis
Internist

Selective Bronchography and Bronchial Brushing

F. Pinet, M. Amiel, A. Rubet and J. C. Froment. Copyright 1979, Springer-Verlag, Berlin. 261 pages, 477 illustrations, \$99.

Over the years, the popularity of bronchography has waxed and waned. Currently, the dwindling number of bronchograms performed in America contrasts with what is apparently happening overseas. At the authors' hospital in Lyon, France, for example, over 1,700 bronchograms have been performed since 1966.

Bronchial catheterization—having been cross-fertilized by new ideas from cardiovascular radiology—has there entered a new phase of development. This field now embraces *in situ* sampling, selective opacification, bronchial dynamics, and manometry. All of these advances are covered by this book, leading the reader to an enriched understanding of bronchial pathophysiology and thus to rational therapy.

The technical advances that have contributed to this renaissance, as well as a complete list of lesions that alter bronchographic morphology, are clearly illustrated. At the descriptive level, pictorially evocative terms like "mistletoe images," "radish-root appearance," and "Jerusalem artichoke bronchiectasis" prove useful and stimulating. Diagnostic fine points and possible pitfalls are emphasized throughout. Particularly valuable chapters include those on bronchitis, bronchiectasis, and pulmonary neoplasms.

This text is firmly based on extensive practical experience and is well supported by references. Recommended for radiologists and pulmonary specialists.

ALAN T. MARTY, M.D.
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Obstetrics and Gynecology
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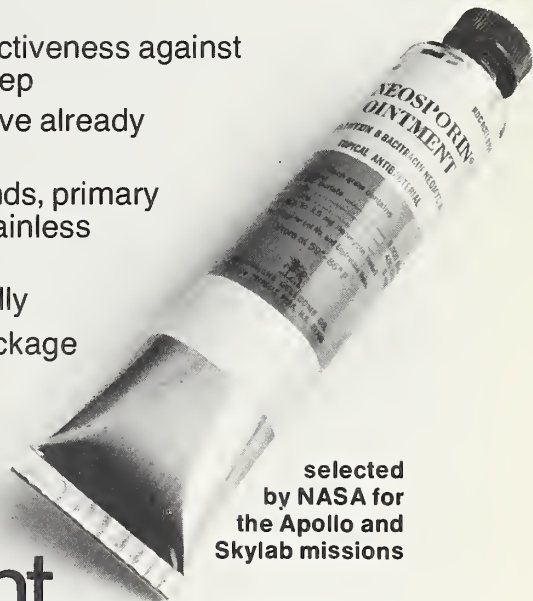
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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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Pathology

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Lambertus, John, Terre Haute
Radiology
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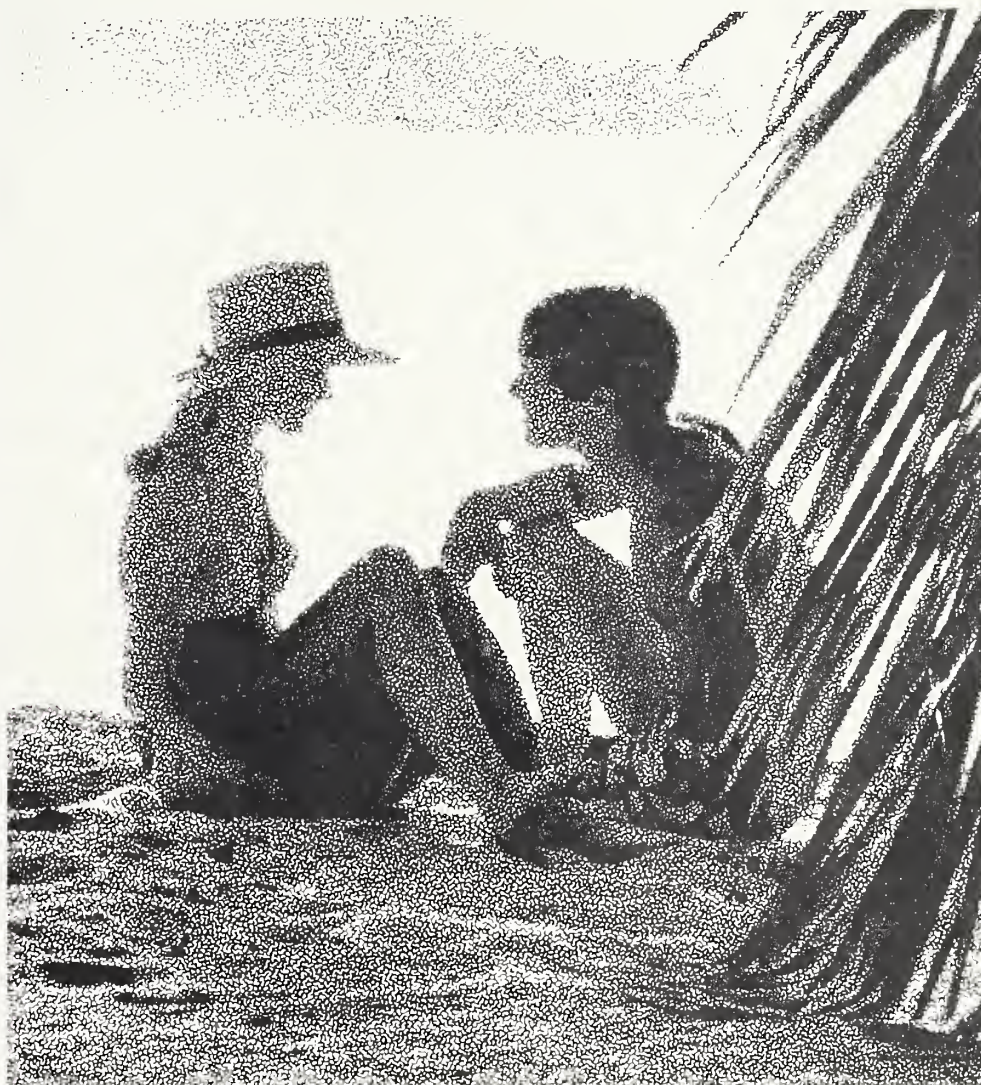
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Dr. Einhorn Appointed Professor of Clinical Oncology, First in Indiana



Dr. Lawrence H. Einhorn of the Indiana University School of Medicine, Indianapolis, has been named recipient of a \$125,000 grant from the American Cancer Society and appointed a Professor of Clinical Oncology, the first in Indiana.

Dr. Einhorn's career in cancer education and control has received international attention, particularly in testicular cancer therapy, according to Dr. Steven C. Beering, dean of the I.U. School of Medicine.

The American Cancer Society's program of "Professorships of Clinical Oncology" was established in 1971 and currently has active professors in 17 medical schools in the U.S.

Journal Stops Publishing Roster

Responsibility for publishing the annual ISMA membership roster has been delegated to the Association's Membership Department. Therefore, the roster will no longer be published as a supplement to the March issue of *THE JOURNAL*.

Paid subscribers to *THE JOURNAL* will be sent a copy of the roster this year, but it will not be provided as an automatic feature of paid subscription in the future.

The Membership Department plans to print the roster this spring, and it will sell for \$20 per copy. ISMA members will be sent a courtesy copy of the roster upon publication—additional copies for members will sell for \$10 each.

For information, write Membership Dept., Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

New Antibiotic Plant

Beecham Laboratories has completed construction of a new oral semisynthetic penicillin manufacturing plant in Bristol, Tennessee. Beecham Laboratories is a division of Beecham Group, Ltd, the British corporation whose researchers have developed many of the semi-synthetic penicillins. The oral products include Totacillin, Amoxil, Bactocill, Cloxapen and Dycill.

Medic Alert Protects Elderly

The Medic Alert Foundation of Turlock, California has a special announcement for elderly people who are the ones who benefit most from wearing the Medic Alert bracelet with an inscription to identify hidden medical conditions which may be of great importance when the person is seen in an emergency situation.

For a one-time, lifetime membership that costs \$10, any person may obtain the alerting device (either a bracelet or necklace) and wallet card, and enjoy the advantage of having his medical history recorded at Medic Alert headquarters available for transmission to emergency personnel anywhere in the world in answer to telephoned requests.

In a recent 12-month period, over 2,000 members reported Medic Alert had contributed to the saving of their lives.

The Foundation's address is P.O. Box 1009, Turlock, California 95380.

Dr. Honan Cited for Ocular Development

Dr. Paul R. Honan, a Lebanon ophthalmologist, has received the American Academy of Ophthalmology's Honor Award for his voluntary contributions to the Academy's continuing education program.

Dr. Honan, director of the Contact Lens Clinic at the Indiana University School of Medicine, Indianapolis, developed an aid for softening eyes before intraocular surgery.

His affiliations include the American Intraocular Implant Society and the Indiana Academy of Ophthalmology, of which he was 1977-78 president.

Here and There . . .

. . . **Dr. Joseph B. Davis** of Marion has received Indiana University's C. G. Clevenger Award, presented for "outstanding contributions to Indiana University through service to its athletic program and I-Men's Association."

. . . **Dr. Pansyotis G. Iatridis** of I.U. Northwest, Evansville, has been approved as an assistant dean of the Indiana University School of Medicine.

. . . **Dr. Elizabeth Sowa** has been elected to the Newburgh Town Board.

. . . **Dr. Robert F. Nagan**, Indianapolis, has been elected a governor of the American College of Surgeons.

. . . The Elkhart County Medical Society has established a medical education scholarship in memory of **Dr. Danny D. Swihart** of Elkhart, who died Dec. 1.

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Contraindication: Previous hypersensitivity to penicillin.

Warnings: Serious, occasionally fatal, anaphylactoid reactions have been reported. Some patients with penicillin hypersensitivity have had severe reactions to a cephalosporin; inquire about penicillin, cephalosporin, or other allergies

before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

[102175]

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Additional information available to the profession on request.



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NEWS NOTES

Hospital Cost Containment

The U.S. Chamber of Commerce has urged Congress to defeat the Administration's hospital cost containment measure on the basis that voluntary efforts, which have proved successful, should be encouraged. A Chamber letter stated that, in addition to being fundamentally flawed, the bill "suffers from several inconsistencies." These were listed as follows:

"It exempts Federal hospitals from controls; yet, these public facilities are showing cost increases greater than those of private institutions.

"It exempts from controls the salaries of nonsupervisory personnel; however, such wages account for as much as two-thirds of a hospital's budget.

"It ignores the fact that regulation itself contributes significantly to rising costs. For example, hospitals in New York State spend over \$1 billion annually complying with government regulations, adding \$40 to every patient's bill."

Diplomates

The following ISMA members have been named diplomates of the **American Board of Family Practice**:

Dr. Parks M. Adams, Jr., N. Manchester;

Dr. George F. Berry, Evansville;

Dr. David L. Clayton, South Bend;

Dr. Chul Choi, Pendleton;

Dr. Marlin R. Gray, Ferdinand;

Dr. Manuel Z. Rosario, Gary;

Dr. Mary Kay Witges, Lafayette.

Fellowships

American College of Surgeons:

Dr. K. V. Pillay, Merrillville;

Dr. Veera Porapaiboon, Merrillville.

American Academy of Family Physicians:

Dr. Gordon T. Robbins, Zionsville.

American College of Obstetrics and Gynecology:

Dr. Kishori Shah, Huntington.

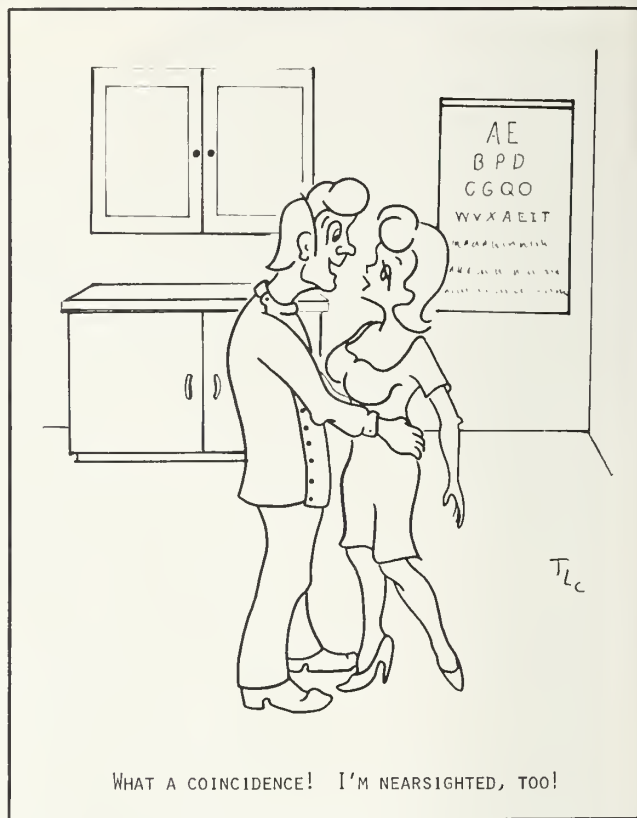
Hospital Elections

Home Hospital, Lafayette—Dr. David F. Alstott, president; Dr. Gordon D. Welk, secretary-treasurer.

Bloomington Hospital, Bloomington—Dr. Timothy Habbe, chief of staff; Dr. Roger A. Reimers, secretary; Dr. James P. Mitchell, treasurer.

St. Elizabeth Hospital, Lafayette—Dr. C. T. Cline, president; Dr. D. J. Sharvelle, secretary-treasurer.

Methodist Hospital, Indianapolis—Dr. Hunter Soper, president.



LaPorte Hospital, LaPorte—Dr. J. Kim, president; Dr. Aldo C. Sirugo, secretary-treasurer; Dr. Charles F. Hagenow, vice-president.

St. Mary Medical Center, Gary—Dr. Raffy A. Hovanessian, president; Dr. Robert T. Woodburn, secretary; Dr. Jerald J. Smejkal, treasurer.

W. S. Major Hospital, Shelbyville—Dr. Richard Goldyn, chief of staff; Dr. James Peters, vice-chief of staff; Dr. Lucia Banguis, secretary.

Bartholomew County Hospital, Columbus—Dr. Michael Free, chief of staff; Dr. Daly Walker, secretary.

Howard Community Hospital, Kokomo—Dr. James Paff, chief of staff; Dr. Alan Crebo, vice chief of staff; Dr. Jivanlal Gohil, secretary.

Parkview Memorial Hospital, Fort Wayne—Dr. Charles Frankhouser, president; Ronald G. Kleopfer, secretary-treasurer.

St. Joseph's Hospital, Fort Wayne—Dr. Linus Minick, president; Dr. Dale Aeschliman, secretary-treasurer.

Cameron Memorial Community Hospital, Angola—Dr. Donald Mason, president; Dr. Larry Watkins, vice-president; Dr. Wayne Schrepferman, secretary.

Elkhart General Hospital, Elkhart—Dr. Forest M. Kendall, chief of staff; Dr. John B. Guttman, Vice chief of staff; Dr. James C. Reed, secretary-treasurer.

'JACEP' Changes Its Name

"The Journal of the American College of Emergency Physicians" (JACEP) was given a new title on Jan. 1. It is now called "Annals of Emergency Medicine" and features a new cover design. It is the official journal of the American College of Emergency Physicians and the University Association for Emergency Medicine. "Annals" will continue its emphasis on the clinical aspects of emergency medicine and expand its coverage of the broad scope of medical and management problems facing emergency physicians.

High Scorers at St. George's

An American medical student from New York state, a student at St. George's University School of Medicine in the West Indies, recently made the highest score of all foreign and domestic students taking the National Board of Medical Examiners examination, part I. Seventeen of St. George's 175 students who took the exam scored above 90%. Included in this group was Stephen L. Gordon of Anderson, Indiana. St. George's is an English-speaking, international school located on the islands of Grenada and St. Vincent.

Generic Drug Substitution

Once again, the issue of generic drug substitution will be discussed by this year's Indiana General Assembly. Proponents of substitution bills are again expected to assert—incorrectly—that substitution is not permitted in Indiana.

Under present state law, any patient can obtain a generic drug, *if the patient's physician approves*. This restriction allows the doctor to retain control of the therapeutic situation, which he or she must do for the patient's protection.

In the 40 states that permit substitution without any restrictions, physicians have no way of knowing whether their patients are getting safe and effective generic substitutes.

Those who advocate state laws permitting free-and-easy substitution argue that generic products are safe and effective because the FDA will not allow any drugs on the market that are not safe and effective. Yet, surprisingly, a major generic manufacturer—in a recent letter to state formulary commissions—says the "assumption that N.D.A. (New Drug Application) approval signifies safety and efficacy is erroneous."

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OBITUARIES

George F. von Asch, M.D.

Dr. von Asch, 65, a LaPorte physician, died Dec. 3 at LaPorte Hospital.

He received his M.D. degree in 1939 from the University of Illinois. He had practiced in Hawaii until 1947, when he moved to LaPorte.

Joseph E. Coleman, M.D.

Dr. Coleman, 58, an Evansville pediatrician 30 years, died Dec. 8.

He was a 1944 graduate of the Indiana University School of Medicine and was certified by the American Board of Pediatrics.

Dr. Coleman was chief pediatrician at St. Mary's Medical Center and was a past president of the city-county board of health, Evansville.

Charles W. Dill, M.D.

Dr. Dill, 52, an Indianapolis physician, died Dec. 6 at St. Francis Hospital, Beech Grove.

He was a 1954 graduate of the Indiana University School of Medicine and a World War II Navy veteran.

Dr. Dill was vice-chief of St. Francis Hospital emergency room services and was director of the hospital's paramedic education program. He was team physician for Indiana Central University athletic programs and, for several years, was a Marion County deputy coroner.

He was a member of the American College of Emergency Room Physicians.

Robert L. Kerrigan, M.D.

Dr. Kerrigan, 90, a retired Michigan City physician and surgeon, died Dec. 30 at St. Anthony Hospital, Michigan City.

He was a 1919 graduate of Rush Medical College and served in the Army during World War I.

Dr. Kerrigan was a member of the American College of Surgeons. He was a senior member of the ISMA and joined the Fifty-Year Club in 1969.

Robert E. LaFollette, M.D.

Dr. LaFollette, 60, a retired New Albany physician, died Dec. 31 at his home.

He was a 1943 graduate of the Indiana University School of Medicine and was an Army veteran of World War II.

David L. Smith, M.D.

Dr. Smith, 83, a retired Indianapolis obstetrician, died Dec. 28 in an Indianapolis nursing home.

He was a 1922 graduate of the Indiana University School of Medicine. He was a veteran of World War II.

Dr. Smith was certified by the American Board of Obstetrics and Gynecology and was a member of the American College of Obstetrics and Gynecology. He became a senior member of the ISMA in 1967 and was enrolled in the Fifty-Year Club in 1972.



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Inside: • **MYSTERY PHOTO FOUND AT I.U.**
Why Did a Medical Lecturer Use It? See Page 123

A character all its own.



Valium (diazepam/Roche) is a benzodiazepine with a character all its own.

Pharmacologically, it is a potent skeletal muscle relaxant and anticonvulsant (in adjunctive use), as well as an antianxiety agent. Pharmacokinetically, only Valium provides active *diazepam* as well as the active metabolites 3-hydroxydiazepam, desmethyldiazepam and oxazepam.

But the individual character of Valium is even more apparent clinically than pharmacokinetically. And far more significant. That's because of the patient response obtained with Valium. A response which brings a calmer frame of mind. A response which has a pronounced effect on the somatic symptoms of anxiety, particularly muscular tension. A response which helps the patient feel more like himself again because of the way Valium reduces the overwhelming symptoms of anxiety and psychic tension.

Another important aspect of the clinical character of Valium is safety. Though drowsiness, ataxia and fatigue are possible, these and more serious side effects are rarely a problem. Of course, as with all CNS-acting drugs, patients taking Valium should be cautioned against driving, operating dangerous machinery or the simultaneous ingestion of alcohol.

Unquestionably, many psychotherapeutic agents, including other benzodiazepines, have antianxiety effects. But one fact remains: you get a certain kind of patient response with Valium. It's a response you want. A response you know. A response you trust as part of your overall management of anxiety and psychic tension.

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The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

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MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

Mystery Photo: Why Was It Shown To Med Students?

The illustration on the cover (reproduced on this page) stands for whatever you want to make of it. It is taken from a glass lantern slide used for a medical lecture by an I.U. School of Medicine professor in the 1920s or 1930s. Who the professor was, what his subject was, and just what medical point this photograph was supposed to make are unknown. The slide was recovered from an I.U. storage area, along with other material that had long since been discarded. Unlabeled, the photograph is without value—at least from the medical point of view.

My interest was caught by the name “Willoughby” on the building on the far right. The Willoughby building in Indianapolis (razed several years ago) was an important center of medical activity at the turn of the century. It was located on Meridian Street north of Monument Circle. But streetcar tracks never existed on North Meridian Street, so the city here obviously is not Indianapolis.

The names of Broadway and Seventh Avenue appear on the streetcar in the rear, suggesting this to be New York City. The automobile in the background on the left, with its chauffeur in high boots and billed cap, and its steering wheel on the right-hand side, looks like a 1913 model, possibly a Locomobile. The height of the skirts of the two women in the foreground on both sides of the street appear to be 4 to 6 inches, compatible with the 1913 date.

The focus of attention is the horse and buggy in the foreground. The driver, with his head turned anxiously toward the approaching



streetcar, is accelerating his horse with a quick flick of his switch on the horse's rump.

Just what is the point of this slide to a medical lecture? I put the slide under very low power of the microscope to see if the numerous signs could be read any better. Next to Willoughby's is the Royal Display Fixture Company on the first floor. Graf Brothers is on the second floor, and a large sign saying “Human Hair” is on the third floor. It is not clear if they are buying, selling, or both. The corner store at the end of the block is a men's fashion store. Coming to the automobile, the number of the license plate is blurred, and the year cannot be discerned. Details of the chauffeur are clear, however. But again, what medical point could this photograph possibly make?

The most obvious feature is the potential collision of the streetcar with the horse and buggy, and of course streetcar accidents were not uncommon. From the photograph alone, however, we don't know that the streetcar is in motion. More likely it's standing still, and the mo-

torman is prompting the buggy driver by clanging the bell.

To me the principal feature of medical interest is the length of the women's skirts. Skirts were at floor level until well past the turn of the century. As early as 1905 the fashion pages of daily newspapers advocated raising the hemline to ankle length, but in looking at photographs of the period few women did so. By 1913 the fashion was commonplace.

The medical interest in this fashion note stems from the relationship of germs, dust and disease. Public-health-minded physicians at the turn of the century were a force in raising the hemline. The long skirt dusted the sidewalks and streets, picking up residues of excreta from horses and spittle (due to the commonplace dirty habit of expectorating). The high incidence of tuberculosis and the common practice of spitting on slates to clean them caused physicians to urge the abolition of this educational device from the public schools, at about the same time and for the same reason.

The JOURNAL of the INDIANA STATE MEDICAL ASSOCIATION

WINNER
Sandoz Medical Journalism Award—1976, 1979

Vol. 73, No. 3
MARCH 1980

USPS 284-440
ISSN 0019-6770

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POSTMASTER: Send address changes to THE JOURNAL, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

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All issues since 1967 available on microfilm from University Microfilms, Inc., 300 N. Zeeb Rd., Ann Arbor, Mich. 48106. Indexed in Index Medicus and Hospital Literature Index.

Advertising rates and data available on request. Representative for national advertising: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302.

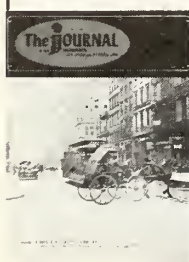
Publication deadline: 1st day of month preceding month of issue.

Subscriptions: \$14 per year, USA; \$16, Canada; \$17, foreign; \$12, libraries; \$10, senior ISMA members; \$8, members; except for special issues, single copies not available. Subscriptions renewable only in January and July.

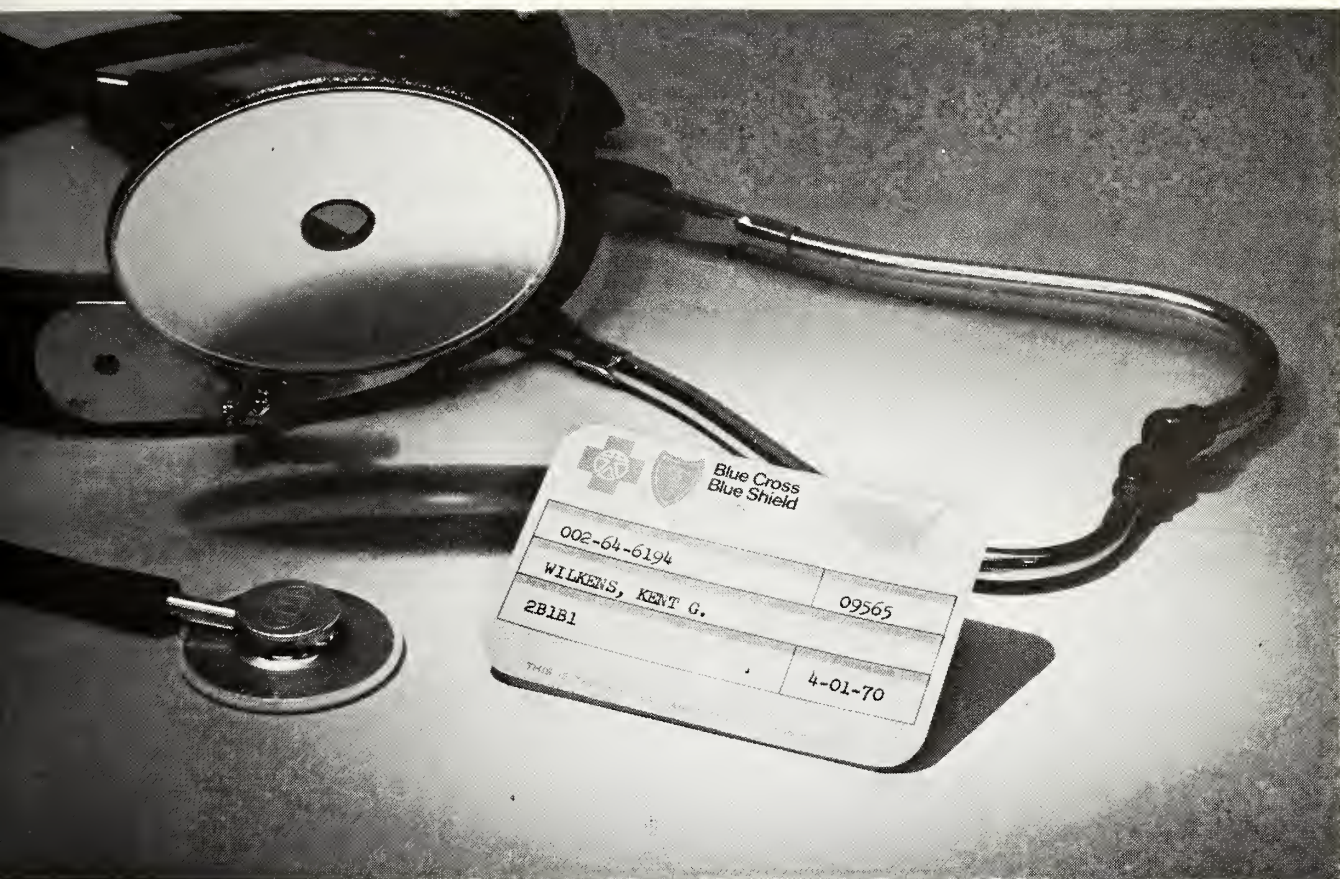
Second-class postage paid at Indianapolis Ind. and additional mailing office.

ABOUT THE COVER

This was the scene along a New York City street in about 1913. Dr. Charles Bonsett, author of Medical Museum Notes, found the picture in a storage area at the I.U. School of Medicine. For his comments on how the picture could have been used in a medical lecture, see Page 123.



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WHAT'S NEW?

SCHERING has introduced Garamycine Intrathecal Injection. It is a preservative-free sterile solution for direct administration into the cerebrospinal fluid spaces. It is used in treatment of meningitis and ventriculitis caused by susceptible *Pseudomonas* species.

DOUBLEDAY has released *Making it as a Stepparent: New Roles/New Rules*. The author, Claire Berman, is spokeswoman for the North American Center on Adoption. The book is based on interviews with hundreds of remarried men and women and their children and takes a look at all angles of the stepfamily situation. 216 pages, \$8.95.

THE 3M COMPANY has a new lightweight cardiology stethoscope which by the use of two tubes enclosed in a larger tube eliminates the tubes rubbing together and provides better sound transmission by maintaining uniform internal tube diameter from chestpiece to ears. It was developed from recommendations by 50 cardiologists. It is sensitive to both high and low frequencies.

MERCK SHARP & DOHME announces a new dispenser for "Timoptic." Addition of a 10 ml "Ocumer" to supplement the 5 ml "Ocumer" will provide greater convenience in the use of the new glaucoma drug. In the treatment of chronic open-angle glaucoma, a single drop applied in each eye twice daily is usually sufficient.

GENERAL NUTRITION CORPORATION has marketed Lysine tablets for relief of lesions caused by the herpes simplex virus. Researchers at I.U. School of Medicine have demonstrated that cold sores, fever blisters and genital herpes are afforded dramatic relief upon administration of lysine. Use is based on the observation that a viral invasion of a cell alters the cell's biological response to lysine and arginine. Providing an abundance of lysine appears to create an environment hostile to the herpes simplex virus.

MERCK SHARP & DOHME announces that Sine-met, a combination of levodopa and carbidopa for treatment of Parkinson's disease, is now available in a new dosage strength that provides an increased ratio of carbidopa to levodopa—25 mg. carbidopa to 100 mg. levodopa. The new ratio is designed to meet the needs of levodopa-responsive patients who are having levodopa side effects that are difficult to control with the 1:10 ratio.

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by **THE JOURNAL** or by the Indiana State Medical Association.



SEARLE announces FDA approval for introduction into the U.S. market of the non-hormonal contraceptive Tatum-T. This is a copper-bearing intrauterine device that is smaller than most IUDs. It releases tiny amounts of copper and in clinical studies was associated with less frequent side effects than other devices. It is small and pliable, places and removes with facility, and is effective for 12 months.

ROSS LABORATORIES has received FDA approval for a new product to combat a leading causative agent of acute otitis media. Pediazole™ is a combination of erythromycin ethylsuccinate and sulfisoxazole acetyl. It is indicated in treatment of susceptible strains of *Hemophilus influenzae*, strains of which are appearing and found to be resistant to ampicillin.

BRISTOL-MYERS announces receipt of FDA approval for three new uses of Stadol® (butorphanol tartrate), the recently introduced, highly potent, parenteral analgesic for relief of moderate to severe pain. The new uses are 1) use as a preoperative medication, 2) use as the analgesic component of balanced anesthesia and 3) use in parturition pain. The new drug is said to be as effective as morphine but does not depress respiratory capacity to any significant extent.

THE VIOLIN CORPORATION has made possible the reprinting and distribution of a symposium on pancreatic disease which originally appeared in *Practical Gastro-enterology*. Quantities of the reprint are available free to members of ISMA for use as training/teaching aid. Address *Practical Gastro-enterology* at 42-15 Crescent St., Long Island City, NY 11101.

SPORTSHEALTH PRODUCTS has a new therapeutic strengthener/conditioner that exercises the total muscular structure of the fingers, hand and forearm. It is a silicone rubber compound called Power Putty™ that has the ability to resist in proportion to the pressure applied against it. It can be squeezed, stretched, pulled, twisted and pinched. It exercises both flexor and extensor muscles. Useful in postoperative muscle conditioning and for athletic muscle conditioning.

DOUBLEDAY has released *Every Body's Fitness Book*, written by Gordon W. Stewart, M.Sc., formerly the employee fitness director for the British Columbia Ministry of Health. His thesis is that the principles of athletic training are unnecessary and sometimes harmful for the non-athlete. Instead he discusses the general principles of fitness and outlines the five basic steps in a fitness program for the ordinary citizens. The book is a paperback edition with 192 pages and 44 black and white drawings which sells for \$5.95.

SQUIBB has a new beta blocker that requires only once-a-day dosage for treating hypertension or angina. Corgard® (nadolol) tablets have a 20- to 24-hour half-life and maintain an effective blood level on once-a-day. The new agent is well tolerated and can be prescribed without regard to meals.

WILLIAM H. RORER announces it will market a new non-prescription laxative under the brand name Perdiem™. It is a blend of vegetable derivatives of psyllium and senna for comfortable and safe relief of constipation. It has a granular formulation and is dispensed in canisters of 100 grams and 250 grams.

DOUBLEDAY has released *The Last Taboo: Sex and the Fear of Death*, by James Lewton Brain. Brain, a social anthropologist, writes about two of the central events in human existence. Of the book, one reviewer wrote, "It is a wise book, and both compassionate and witty in making sense of the sexual muddle." 264 pages, \$8.95.



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EDITORIALS

'Best Doctors' Book Called Useless in Picking Physician

The recently published book, *The Best Doctors in the U.S.: A Guide to the Finest Specialist Hospitals and Health Care Centers*, has been reviewed by Dr. William R. Barclay, editor of *JAMA*. He notes that, while the physicians recommended by the author are section chiefs and department chairmen of medical schools, there are equally capable men and women in private practice who are not consumed with teaching, research and administration.

Dr. Barclay opines that the best medical care is obtained not only in university centers but also in nonacademic centers and in community hospitals. His advice to the public in regard to finding a good physician is to consult the local medical society, not the book.

Revision to Medicare Reg Misinterpreted, Misunderstood

A revised Medicare regulation, dated Nov. 29, 1979, has been widely misinterpreted and misunderstood.

Medicare law (Section 1879) provides that when a beneficiary receives care and a claim is submitted and paid by the program for services later determined to be either medically unnecessary or custodial, patient liability for the amount thus overpaid will be waived if the patient did not know the service was not covered.

Regulations pertaining to this section, published in January 1975, stated that the patient would be presumed not to know about such exclusions in the absence of evidence to the contrary. Further wording in the regulation suggested that such evidence might be received by the patient by oral communication.

The only change affected by the Nov. 29 regulation is to the effect that only written evidence is acceptable in such a case.

The regulation makes no change in physician-Medicare relationships. The law (Section 1879) applies to physicians only on claims for which they have accepted assignment, and the only situation in which Medicare

would recover from the physician any amount paid by the patient would require:

- That the physician accept assignment on the case;
- That he collect from the patient some portion of his charge over and above the deductible and coinsurance;
- That Medicare pays the claim and then finds that the service is either medically unnecessary or custodial; and
- That the physician knew the claim would be considered medically unnecessary or custodial when he filed it.

There is no provision either in this section of the law or in the pertinent regulation whereby any amount can be recovered from a physician as a Medicare overpayment unless Medicare has first paid that amount to the physician on an assigned claim.

Under both the Nov. 29, 1979, regulation and the January 1975 regulation, the major responsibility for written notices rests with intermediaries or carriers, with utilization review committees, and with providers, not with physicians.

Prescription Drug Coverage For Nation Would Cost Billions

Financing prescription drug coverage under a national program will require from \$2.6 to \$18.3 billion in new taxes, according to Gordon R. Trapnell, the country's leading expert on the cost of government health insurance programs.

The study, made possible by a grant from Roche Laboratories, is the first of its kind to focus on outpatient prescriptions.

The following factual statements were developed as a result of the study:

- Total spending for outpatient prescription drugs in 1978 amounted to \$10.5 billion, compared to \$6.8 billion in 1972. This increase was less than the rate of inflation, despite increases caused by demographic factors, average prescription size and introduction of new products.
- Pharmaceutical manufacturers' prices and retailers' average markups lagged basic inflation by 13% and

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15%, respectively, between 1972 and 1978.

- Should there be no national prescription drug program, expenditures for prescription drugs in 1983 will be \$17.4 billion.

- Such national spending could increase to \$24.9 billion in 1983 if a comprehensive national prescription drug plan is fully implemented.

- National prescription program outlays, if financed by the Federal Government, will range from \$2.9 billion for an income-related plan for the aged and chronically disabled, to \$19.4 billion for a comprehensive plan for the entire population. Additional taxes required will range from \$2.6 billion to \$18.3 billion, respectively.

How Much Exercise Is Good for You?

Despite the almost universal acceptance of the proposition that physical activity is necessary and advantageous for the human race and especially for the elderly members of it, there is surprisingly little agreement on the subject of how much activity, in each individual case, is beneficial.

The lack of specific knowledge in this regard also extends to the difficult subject of determining, in each individual case, how the activity should be monitored in the event the quantity has been accurately prescribed.

Dr. Zeb Kendrick, assistant professor of physical education at Temple University, who specializes in exercise physiology, says, "Scores of elderly citizens are caught up in the physical fitness kick and are exercising strenuously without knowing their body's capabilities."

Dr. Kendrick thinks that the only criterion set for the elderly is the idea that if you feel good physically you can set out on some type of moderate exercise program.

Dr. Kendrick also gives the only rule for geriatric exercise plans: "If you get to the point where you can't carry on a conversation because you're out of breath, it's time to stop."

He observes that we now live in a society where the kids are watching TV and the adults are out jogging.

Dr. Kendrick is planning a physical education course at Temple this summer, "Exercise During Aging." He hopes to develop, through research and well oriented study, specific knowledge about age-related changes in liver and kidney function that may alter the rules for safe exercising in the later years. He would like to know more about the effect of drugs on the older person's ability to exercise and benefit from it.

Certainly, it is high time to have some rational rules about physical activity. If there is as much jogging going on in Philadelphia as there is in Indiana, Dr. Kendrick should be well supplied with subjects for his research. More power to him.

CONTINUED ON PAGE 142



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Let's Take The Profit Out Of Doing Nothing

Guest Editorial

RICHARD L. LESHER
President
U.S. Chamber of Commerce

With a touch of brilliance, former President Calvin Coolidge once observed: "When more and more people are thrown out of work, unemployment results." Were he alive today, he might add that when unemployment compensation is sufficiently generous, many recipients lose their incentive to work.

Unemployment compensation was not meant to become a giant giveaway program. It was designed as a needed safety net during the 1930s to protect the millions of people who were plunging toward financial disaster, or who had already been wiped out. Regular unemployment checks helped families pay their bills until the crisis subsided and the breadwinners could return to work. That, at least, is the way the system used to work.

Times have changed. Today, unemployment compensation is no longer just a financial safety net. For more and more Americans it has become a semi-permanent way of life. Some of the abuses even seem commonplace.

- There is the young college graduate who could work, but who would rather stay home and play the guitar while collecting unemployment compensation.

- Or what about the man who is weary of his work, wants a change and doesn't mind the public picking up his tab while he decides what to do?

- And, of course, let's not forget all those who head south each winter to frolic in the surf while pretending to look for jobs.

The point is not that Americans, by nature, are dishonest. Certainly some people do deliberately

cheat, but the majority are still honest. The real problem is with the unemployment compensation program itself. People tend to respond rationally whenever they are given incentives to work more—or less. The message the unemployment compensation program now sends is clear for anyone willing to listen. In so many words it is saying: "Do not be concerned about substituting subsidized leisure for taxed work. In fact, be our guest!"

The General Accounting Office, Congress's official watchdog agency, recently issued a report explaining how this problem developed, why it is so serious and how it can be corrected.

The GAO notes that the program's benefits were originally set at 50% of gross wages back in the 1930s—a time when little or no difference existed between gross and net wages. The interim years have witnessed huge increases in federal, state and local income taxes, as well as Social Security taxes. So today, a taxfree check amounting to 50% of one's gross pay does not represent nearly as big a loss as it did when the program began.

Result? GAO interviews with 3,000 unemployment recipients nationwide established that, on average, people can expect the program will replace almost two-thirds of their former weekly net pay. Fully 7% of the recipients actually received more money from unemployment compensation than they took home from their former jobs. GAO investigators also reported that "the absence of work-related expenses during unemployment increases the net value of unemployment compensation. Such expenses as transportation (and) child care are quite substantial while working and cease during periods of unemployment."

The report urged strong measures to rid the program of its existing inequities and disincentives. These include making unemployment compensation subject to the personal income tax and reducing benefits by the amount of retirement income an individual is receiving.

Two years ago, I warned that, while we need a short-term jobless program to assist those in need, we cannot afford permanent subsidies to create a new leisure class. Congress has still not grasped that distinction. Until it does, those who work will be hit with higher taxes and inflation to support those who seek a profit for doing nothing.

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DURING PREGNANCY: Give one to two rounded teaspoonfuls each evening.

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LETTERS

Says 'Split Atoms, Not Wood' Distorts Several Basic Issues

Near the beginning of his guest editorial, "Split Atoms, Not Wood," (THE JOURNAL, November 1979) Richard J. Noveroske, M.D., makes a statement of a curiously contradictory nature: "Congress appeared to be afraid to mention nuclear power because of fear of reprisal at the ballot box in the November 1978 elections." If the opponents of nuclear power are indeed numerous enough to effect reprisals at the ballot box, the implication is that they are a majority, and as I understand it, Congress is in business to carry out the will of the majority.

Be that as it may, Dr. Noveroske distorts several basic issues in his arguments for nuclear power generation.

One distortion is the economic factor. The fact is that if the consumer had to pay the total cost of nuclear-generated power via utility bills, no one could afford it. The government has poured billions of taxpayer dollars into the industry. And bear in mind that a reactor becomes literally "too hot to handle" after 20-30 years in operation. It then must be closed down and sealed off, leaving the site unproductive and necessitating tight security for farther into the future than we can comprehend. This not only represents a tremendous loss in terms of the site and the structure, but necessitates construction of a monstrously expensive replacement facility on another site.

Another distortion is the matter of wastes. Yes, they can be isolated, sealed, and buried. But they don't stay that way. With increasing frequency, these wastes are coming back to haunt us in the form of leaks that create a dangerous level of radiation resulting in a high incidence of birth defects, leukemias, and other cancers in areas surrounding the burial sites. Helen Caldicott, M.D., in the March 1979

issue of PHYSICIAN EAST, defines the parameters of biological damage resulting from the massive radioactive leaks we are beginning to experience.

Daniel F. Ford, writing in the newsletter of the Union of Concerned Scientists (1208 Massachusetts Avenue, Cambridge), states that current nuclear industry plans, if carried out, will result in an accumulation during the next 22 years of 90,000 tons of used reactor fuel. These wastes will remain deadly for at least a quarter of a million years. Virtually every federal waste facility has begun to leak; more than 500,000 gallons have already leaked from storage tanks to contaminate our environment.

A few years ago, the nuclear proponents were forging ahead while confidently predicting that a solution to the waste problem was imminent. Today they will admit that we're no closer to a solution than we were 20 years ago.

In this context, of direct and vital concern to the medical profession is the fact that radioactive wastes from nuclear arms and nuclear power generation have already filled available dump sites to capacity, creating a crisis situation in the disposal of low-level radioactive waste materials from medical research. This poses a real threat to the future of vital research projects.

A third distortion is the implication that because other countries are proceeding, we should also. "Because everyone's doing it" has never been justification for anything. Such juvenile rationalization should have no place in mature and informed debate.

Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is encouraged. Letters should be addressed c/o THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

Another distortion relates to the Three Mile Island incident. True—there was no steam explosion, but there are increasingly persistent reports that it came very close. There have been numerous other incidents that, so far as we can learn, have come close to being immediate disasters, and we appear to be on borrowed time in this regard. Also, there is no way to predict how extensive the long-term effects will be.

Dr. Noveroske is correct in his assessment of the hazards of burning coal. Ultimately, coal is also unacceptable. However, its hazards are more manageable than those of nuclear power generation, and it appears that coal is the most viable short-term solution to some of our energy problems.

Amory Lovins, a disciple of the late British economist E. E. Schumacher, and an expert in the field of energy, has constructed a carefully detailed plan for adequately meeting our nation's energy needs *without* necessity for the danger and expense of nuclear power generation. This plan calls for a gradual increase in the use of soft energy technologies while utilizing gas and oil as available and coal as necessary, and gradually phasing them out. (Lovins, Amory B.: *Energy Strategy: The Road Not Taken. Not Man Apart*, published by Friends of the Earth, San Francisco, 6:20, 1977.)

Besides the obvious economic and safety advantages inherent in the soft energy technologies, there is the added benefit of small localized generating units; when one is disrupted, only a small area is affected. This also makes sabotage much less of a threat.

In addition to Dr. Caldicott, numerous other physicians have voiced opposition to nuclear power generation and/or nuclear arms manufacture. These include—but certainly are not limited to—the following:

CONTINUED ON NEXT PAGE

Says 'Split Atoms, Not Wood' Distorts Several Basic Issues

CONTINUED FROM PAGE 135

Val Catanzarite, Medical Student, letter to *American Medical News*, June 22, 1979.

Eric Chivian, M.D.; Alexander Leaf, M.D.; Oliver Cope, M.D.; Thomas Winters, M.D.; and H. Jack Geiger, M.D.; Physicians for Social Responsibility, Cambridge, MA., letter to the *NEW ENGLAND JOURNAL OF MEDICINE*, October 4, 1979.

Wendelin W. Schaefer, M.D., Sheboygan, Wisconsin, Chairman, SMS Committee on Environmental Health, In Perspective: AMA's "Health Effects of Energy Generating Sources" position questioned. *WISCONSIN MEDICAL JOURNAL* 78:14, April 1979.

Elouise Parsons, M.D., Neponset, Illinois: Meet Dr. Elouise Parsons. *CHICAGO MEDICINE*, 82(8):433, 1979.

Allen Graham, M.D., St. Johnsbury, VT; George A. Dodge, M.D., Portsmouth, NH; Donnell W. Boardman, M.D., Acton, MA; Henry S. Harvey, M.D., Littleton, MA; John S. Hughes, M.D. and John S. Rolland, M.D., New Haven, CT; and Richard P. Ingrassi, M.D., Newton, MA: Reflections from Seabrook (letter). *NEW ENGLAND JOURNAL OF MEDICINE* 299(9), 1978.

C. D. Haagensen, M.D., Columbia University, and Harriet Bernheimer, M.D., State University of New York, were among the more than 2000 signers of the *Scientists' Declaration on Nuclear Power*, presented to Congress and the President on the 30th anniversary of the bombing of Hiroshima. That declaration says, in part,

"... the country must recognize that it now appears imprudent to move forward with a rapidly expanding nuclear power plant construction program. The risks of doing so are altogether too great. We, therefore, urge a drastic reduction in new nuclear power plant construction starts before major progress is achieved in the required research and in resolving present controversies about safety, waste disposal, and plutonium safeguards. For similar reasons, we urge the nation to suspend its program of exporting nuclear plants to other countries pending resolution of the national security questions associated with the use by these countries of the by-product plutonium from United States nuclear reactors."

The ultimate question is not whether we can live with nuclear technology; the answer to that is that we probably can, but we cannot determine at what cost physiologically, ecologically, or financially. The significant question is whether there is a better way to meet our energy needs, and the answer to

that is an unqualified yes. Using nuclear-generated electricity to light our houses is like using a chain saw to cut butter; the inefficiency involved boggles the mind. It's time we directed our resources toward the development of safe, clean, efficient, self-renewing technologies. We should have done it years ago, but it's not too late.

ELEANOR BELL
1206 MacVicar
Topeka, Kansas 66604

The Author Replies—Cites Threshold vs. Zero Dose

Your rebuttal is well written. It shows intelligence and the ability to write clearly and with feeling.

Your major premise appears to be that all radiation is dangerous—that radiation is injurious to us right down to zero dose.

My major premise is that radiation only gets dangerous when a threshold dose is reached. And this threshold dose is seldom if ever reached in nuclear power generation of electricity or medical diagnostic radiation.

About 13 years ago I met an Indian graduate student in genetics at my brother's trailer one evening, and he said to me, "You know that the concern about genetic effects of radiation is over, don't you?"

"If it is, the news hasn't filtered down to us radiologists," I answered.

He gave me a reference. I checked it out, read it, and was impressed by it. I wrote and talked with the authors, Doctors John Gowen and Janice Stadler, at the Foothills Campus of Colorado State University at Fort Collins, Colo.

They had exposed four inbred strains of mice to continuous radiation at different levels for 10 generations at the time they reported in a symposium published in 1966. Later their work was carried out to

35 generations of mice. I enclose a copy of their paper, written near the end of their work and published in the October 1967 issue of *Environmental Research* ("Life in Environs of Continuing Higher Levels of Added Radiant Energy from Puberty to Death as Expressed by Mice").

Unlike the usual radiation research where organisms such as fruit flies or mice are exposed to acute, explosive doses of radiation, the researcher plots decreasing doses and their effects on a graph, and then extrapolates down to zero dose. Doctors Gowen and Stadler worked with continuous low doses of radiation—more like what we humans experience and what we are concerned about.

They found that radiation to the germ cells did not carry over to the progeny soma cells of the next generation.

They found no more birth defects in the progeny of mice exposed to radiation ranging from 0.15 roentgens per hour to 3.48 roentgens per hour, when these mice were compared with control mice that lived outside the cobalt radiation—even unto the 35th generation! It would take a controlled human experiment lasting over 700 years to match that one, and you're not going to get it.

Doctors Gowen and Stadler did find somatic effects of radiation, of course. With the higher levels of radiation, like 2.36 r or 3.48 r per hour, there was marked life shortening. With the smallest level of increased radiation, 0.15 r per hour, the average life span of mice decreased from the 525 days of the control mice outside the cobalt room to 507 days. But 0.15 roentgens per hour is over 10,000 times the dose that mice (and men) ordinarily get. Background radiation is usually less than 0.15 roentgens per year.

With 0.20 r per hour of added radiation, the average life span of the mice was 501 days.

CONTINUED ON PAGE 138

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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The Author Replies — Cites Threshold vs. Zero Dose

CONTINUED FROM PAGE 136

I think you can see that 10,000 times the normal amount of background radiation is close to the threshold for effects on body cells from radiation.

Try to show these facts to radiation fighters in and outside our governments, though, and you run into a brick wall. For after all, radiation fighters make their livings from fighting radiation. If you decrease the hysteria, you threaten their jobs. So Gowen and Stadler's work is mainly ignored.

Mueller got the Nobel Prize for showing that explosive doses of radiation injured the progeny of fruit flies, and he helped usher in an age of radiation hysteria.

Gowen and Stadler showed that the progeny of mice weren't injured by many generations of accumulated radiation, and they got nothing. Near the end they could hardly feed their mice, let alone get prizes. Mice, like men, are mammals. They are higher on the evolutionary scale than fruit flies and have been evolving in radiation for eons.

I hope that with time you may see the need of radiation to reach a threshold level, like other physical and chemical factors, before it injures a person.

RICHARD J. NOVEROSKE, M.D.
Evansville

Thanks THE JOURNAL For December's Cover

I would like to express my personal gratitude and the gratitude of the American Lung Association for the inclusion of the Indiana 1979 Christmas Seal as the cover of your December 1979 issue of THE JOURNAL. It also was quite appropriate in my estimation to include two pertinent articles, one on the filter

cigarette controversy and the other on the Smoking Chimp.

We thank you again for the recognition of the American Lung Association in celebration of its 75th anniversary as the nation's oldest voluntary health agency.

JOHN D. MILLER, M.D.
Representative Director, Indiana
American Lung Association

Attempts Underway to Clarify Medicare, Medicaid Confusion

The following letter recently was sent to the director of Professional Relations, Blue Cross/Blue Shield of Indiana, Indianapolis. It is reprinted here at the request of the ISMA Board of Trustees. Based upon recommendations contained in this letter, Blue Cross/Blue Shield is studying the possibility of designing a simplified claim form. When the study is completed, a seminar for medical directors and staff physicians of nursing home facilities will be arranged to explain, among other things, the Medicare and Medicaid differential payment system. (Medicaid cannot pay more than Medicare.) It is expected that such a seminar will be arranged in March or April.

Since the start of Medicare and Medicaid, Indiana physicians have been in a total state of confusion as to what is considered necessary care for these patients and how to bill to receive proper payment for their service. Various components in the Indiana State Medical Association have been confronted with these problems and have made certain observations and suggestions for clarification. Their actions have been approved by the House of Delegates, Board of Trustees and Executive Committee of this Association. It is therefore submitted that the following remarks represent the views of the 5,500 members of ISMA.

Indiana physicians refuse to believe that a lay group should man-

date the number of visits required to treat a patient. They deem it unnecessary to visit the skilled care patient strictly on a 30-day basis and will not maintain the charts and recertification records on this basis. The savings, with this order rescinded, is almost inconceivable.

Once the service has been rendered, payment becomes a complicated, inefficient, time-consuming matter. The processing may take three to four months and then be most unsatisfactory because of the variations in the amount allowed. A simplified billing would again produce a fantastic savings.

The Utilization Review Teams are practically useless in the manner used at the present time. Precious time has been spent to no avail because the determinations seem to carry no authority. Various audit teams make their own investigations without consideration of the expertise of the UR Committee members, and the decisions are not accepted as a true find. Money and time have been lost again with duplication of services.

Medical directors have been both embarrassed and disregarded for decisions made in their facilities. Yet, a great amount of dedication has been displayed by these physicians while trying to adhere to ridiculous paperwork which takes away valuable time from the patient care programs. The syndrome "if it is not written, it didn't happen" must be eliminated. The actual results of his or her direction must be recognized even though paperwork is not documented. An experienced M.D. must be given the courtesy to know good patient care even though the rules and regulations say he or she did it wrong.

Much conflict and misunderstanding have been created by the inconsistent interpretation of the rules and regulations by the audit and survey teams. No doubt the rules are guidelines and should be considered as such, but the "down the middle of the road" adherence

CONTINUED ON PAGE 173

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FUTURE FILE

Annual MacKenzie Seminar

The Annual MacKenzie Seminar, sponsored by St. Mary's Medical Center, Evansville, will be conducted Thursday, April 17, at the Center.

The seminar will begin at 1 p.m. Subjects include applied laser physics, clinical use of lasers in neoplastic and non-neoplastic lesions, laser complications and future applications.

The program is accredited for four AMA Category 1 hours and four AAFP prescribed hours. It also is approved for four credit hours by the American College of Obstetricians and Gynecologists.

For information, contact W. Thomas Spain, M.D., St. Mary's Medical Center, 3700 Washington Ave., Evansville, Ind. 47750. Tel: (812) 479-4000.

Kentucky CME Courses

The University of Kentucky will conduct CME courses on "Birth Asphyxia—Prevention, Management, Outcome" on March 24; "Recent Advances in Treatment of Diabetes" on April 11 and 12; and "Medical Aspects of Sports" on May 5 and 6. Each course will be held in the Hyatt Regency Hotel, Lexington, Kentucky.

For further information write to or call Frank R. Lemon, M.D., College of Medicine, University of Kentucky, Lexington, Ky. 40536. Tel: (606) 233-5161.

Medicine's Legal Aspects

"Legal and Ethical Aspects of Treatment for the Critically and Terminally Ill Patient" is the subject of a two-day conference to be held April 18-19 at the Biltmore Hotel, Los Angeles. It is sponsored by the American Society of Law & Medicine.

The fee, which includes a volume of conference materials and two lunches, is \$110 for members of the Society and \$130 for non-members. Issues to be discussed include withholding treatment, orders not to resuscitate, dilemmas in newborn intensive care, and brain death.

Contact the Society at 520 Commonwealth Ave., Boston 02215.

Gynecologic Cancer

Gynecologic cancer will be the subject of a national conference to be conducted by the American Cancer Society at the Los Angeles Hilton, Oct. 9-11. No registration fee is required, but advance registration is requested.

The session is approved for 16 hours of AMA Category 1 credit and for 16 AAFP prescribed hours.

Write to Nicholas G. Bottiglieri, M.D., 777 Third Ave., New York City 10017.

Humanities Seminars Planned

The National Endowment for the Humanities will sponsor eight seminars this summer for physicians, nurses and other health-care professionals.

The program will feature month-long seminars directed by distinguished historians, medical teachers, social scientists, philosophers and other scholars at selected colleges and universities throughout the country. Its purpose is to advance public understanding and use of the humanities by giving professional leaders the chance to explore a wide range of issues of national concern.

Three professional seminars are open only to physicians, nurses and other health-care practitioners, including public health officials and hospital administrators. Five interprofessional seminars are offered for health-care practitioners and members of other professions.

Topics include ethical and legal issues raised by technological advances in human genetics, the political dimensions of public policy issues in health care, and historical perspectives on contemporary health issues.

From 12 to 15 persons attend each seminar tuition-free, receiving a stipend of \$1,200 plus reimbursement for travel. The application deadline is April 14.

For applications and details, contact the Professions Program, Fellowships Division MS-101, National Endowment for the Humanities, Washington, D.C. 20506.

Acapulco World Symposium

The Fifth World Symposium on Pediatric Surgery will be held at the Acapulco Princess Hotel in Acapulco, Oct. 15-19. The program will be simultaneously translated to Spanish, English and Portuguese.

For details, write Congress Unit National Institute of Pediatrics DIF, Insurgentes Sur 3700, Mexico 22, D.F., Mexico City.

Primary Care Patient Education

The Fourth National Conference on Patient Education in the Primary Care Setting will be held May 21-23 at the Hyatt Regency Hotel, Memphis, Tenn.

Full information is available from Donna Miller, Ph.D., 66 N. Pauline, Suite 233, Memphis 38105.

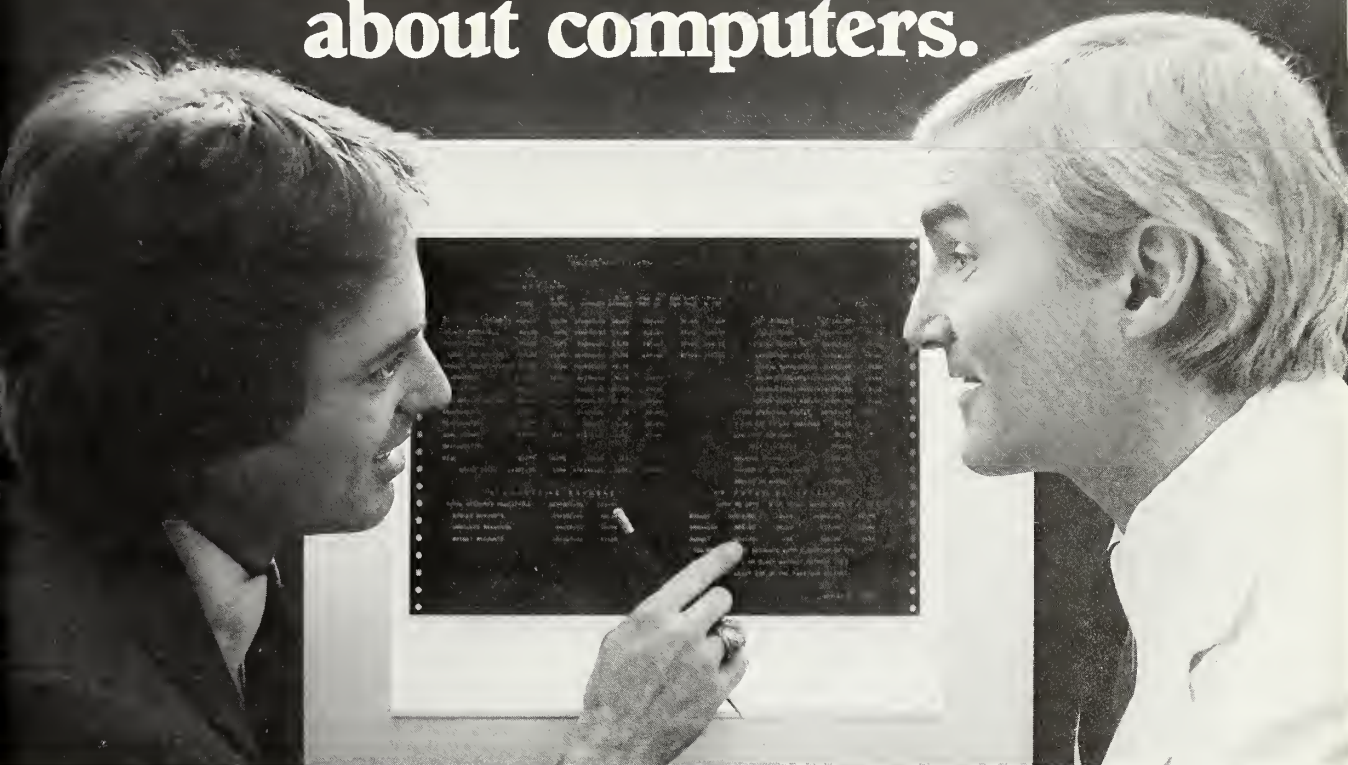
Bronchoesophagology Meeting

"The Third World Congress on Bronchoesophagology" will be held in Palm Beach, Fla., April 9-11.

The conference, designed primarily for endoscopists, has been approved for 15 Category I credit hours. The tuition fee is \$150.

For details, contact Dale E. Braddy, Director of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068.

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EDITORIALS

CONTINUED FROM PAGE 129

Goyan and the FDA

It has been said many times that uneasy lies the head which wears the crown. Perhaps the same is coming true for the new FDA commissioner, Jere Goyan.

Dr. Goyan is a forthright and honest individual. However, he has not dealt with the press corps in Washington. They want to pounce upon any remark of Goyan which could become a news item.

In our opinion, Goyan needs to develop the political savvy needed for survival in his job. His statements to the effect that our nation could reduce the number of prescriptions by one half and still meet the therapeutic needs of the population does not project the pharmacy profession in the most appropriate manner. — ACTION IN PHARMACY, January 1980

Barbiturates Promote Cancer

Notre Dame's Lobund Laboratory has demonstrated that some malignancies in rats will grow faster if the animal is fed a barbiturate. There is no evidence that barbiturates will initiate the tumor, but they will definitely enhance its growth. Also, in a special strain of rats, intestinal tumors can be induced by administration of dimethylhydrazine; such induction is enhanced by giving a barbiturate in addition. If humans react in this way, those with malignancies should not receive barbiturates.

Influenza Prevention, Treatment

A National Institutes of Health Consensus Development Conference on amantadine in October 1979 developed the following conclusions:

1. Under appropriate epidemiologic and clinical conditions, amantadine hydrochloride should be used in the prevention and treatment of influenza caused specifically by strains of influenza A.

2. Amantadine hydrochloride should be considered complementary to active immunization with influenza vaccine in influenza control programs.

3. The public and the medical profession should be made more aware of the need for and approaches to preventing influenza.

The Waiting Game

THE LANCET, in its Feb. 10, 1979, issue, reports an inquiry by a member of Parliament concerning the waiting time, in the member's district, for a hernia operation and a gall bladder operation. The answer was 69 weeks for hernia and 28 weeks for gall bladder. This was compared with statistics for the same operations for all of England and Wales—20 weeks for hernia and 15 weeks for gall bladder. The above figures were compiled Dec. 31, 1975. A footnote gives the figures for the member's district at present—get ready!—Hernia 106 weeks and gall bladder 59 weeks.

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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

Product Information as of September, 1977

U.S. Patent 2,985,558

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AUXILIARY REPORT

Charlotte (Mrs. Abner P.) Bennett
President, ISMA Auxiliary

How do you handle your time? This question was asked at a Time Management Seminar held during the AMA Auxiliary Confluence. The speaker was David Schmidt, president of Management Development Associates.

Productive management of time is a major problem, Mr. Schmidt noted, explaining that since time is limited all of us must learn to control intrusions so that we can do our jobs more efficiently, enjoy our leisure, or reach our goals in volunteer activities.

Here are some pointers on how to conserve this valuable but intangible commodity:

- The telephone is a major thief of time. How can you get off a phone without alienating the person at the other end of the line? Preplanning important telephone calls guarantees that pertinent information will be discussed; it also eliminates unnecessary conversation. If a call occurs at an inopportune time, tell the caller you would like to continue but at another time; set the date and the hour when you will call back. To save time, there are four ways to end a telephone conversation: If you have a monologue on the other end of the line, repeat the person's name until he or she stops talking; summarize the conversation; ask no more questions; finally, hang up first, regardless of who initiated the call.

- How do you get more done in less time? Delegate! It's an art that pays dividends. When giving instructions, never ask the person if he or she understands. That's the road to chaos. The response is always yes even if questions exist be-

TIME: A Source of Stress That Can Be Avoided

cause no one wants to look bad. Give the instructions, ask how the job will be handled, and determine what sort of help would be beneficial. If a time limit exists, state it and then ask when you can expect to have the work finished. Always get a firm commitment on the time.

- Planning is the key to expeditious use of time. A pocket calendar is a must. Writing information and appointments on scraps of paper or match book covers, which can be mislaid or lost, is not recommended. Instead, 3x5-inch calling cards reflecting your name and that of your secretary or fellow executive are much more efficient. Such cards are too large to be mislaid, yet they are large enough to accommodate written messages. They also provide the individual an alternate number to call, which can save you time. It's considered wise to have a

distinctive card that can be remembered.

- In volunteer or organizational work, beware if someone asks your advice on how to do something. Don't give advice. Counter a question with a question: "How do *you* think it ought to be done?" Otherwise, you may find *yourself* doing the job.

- Don't fall into a time trap. Beware of being made to feel really good—pleasurable strokes. Someone may be priming you for a job, which is fine if you want it. If not, you have another thief of your time. A time trap occurs when someone else dictates what you'll do with your time. Learn to say no without feeling guilty. If you're the leader of an organization, define your objectives, then limit them; too many may hinder the completion of any of them.

Time management affects all of us but has received relatively little attention. Time is not expandable, but its poor management is a major source of stress.

While all of these management tips are pertinent, one of the most valuable is the planning of activities on a weekly or biweekly basis. Stating the major task that must be accomplished will eliminate "busy work." The planning should be done at the same time every week, with the activities numbered in their order of importance to you or your organization. Your worksheet should be no longer than one page. When the most important goals have been achieved in order, the end of the week will see you with a sense of accomplishment.

Management of time—think about it!

CANCER CORNER

A Consensus Development Conference on Steroid Receptors in Breast Cancer was held at the National Institutes of Health June 27-29, 1979. It was sponsored by the NCI's Division of Cancer Biology and Diagnosis. The basic question asked at the meeting was:

What is the value of steroid receptor assays to the clinical management of breast cancer?

Following is the list of conclusions drawn by the NIH consensus development panel:

1. The original results from the 1974 NCI-sponsored meeting on estrogen receptors and human breast cancer, showing the utility of estrogen receptor assays in the management of advanced breast cancer patients, have been confirmed and are found to be strengthened significantly by studies over the last five years. Clearly, few patients whose breast cancers lack cytosol estrogen receptors respond to endocrine therapies, while more than half of patients whose tumors contain estrogen receptors obtain objective remissions from such treatments. Thus, results of estrogen receptor assays provide valuable information for making the clinical decisions on the type of therapy to be employed.

For most early breast cancer patients sufficient primary tumor should be available for cytosol estrogen receptor assay. At time of recurrence, the metastatic lesions may be inaccessible or otherwise difficult to obtain. It is strongly recommended that each primary tumor be assayed for estrogen receptor so that the assay information will be available when needed at the time of disseminated disease. Current findings indicate that the cytosol estrogen receptor assay result on the primary tumor correlates well with response to endocrine therapy later, even though the time

interval between assay and therapy may be more than several years.

2. It is evident that while almost all breast cancers which respond to endocrine therapy contain estrogen receptor, not all estrogen receptor containing breast cancers respond to endocrine therapy. To obtain additional confidence concerning the probability of patient response to endocrine therapy, one can determine actual quantitative amounts of estrogen receptor since it appears, in general, that patients with tumors containing higher concentrations of cytosol estrogen receptor have an increased likelihood of response to endocrine therapy. Furthermore, knowledge of whether the tumor contains cytosol progesterone receptor seems to add appreciably to the ability to predict whether the patient will respond to endocrine therapy.

3. At present, there does not appear to be any histopathologic feature that can predict the estrogen receptor status of the cancer, although more highly differentiated tumors (i.e., histologic grade I) appear to have a higher proportion containing estrogen receptor than do the more poorly differentiated tumors.

4. There is no clear evidence that responses to chemotherapy correlate with the presence or absence of estrogen receptor. More basic laboratory and/or clinical studies are in order to understand how cancer cells are being affected by cytotoxic agents.

5. Stage II patients with tumors that lack estrogen receptor appear to recur earlier than those with estrogen receptor positive tumors, independent of the size of the tumor or nodal involvement. Regarding the length of survival or the prognosis for recurrence of Stage I patients, more data must be accumulated to determine whether

the estrogen receptor status correlates in these cases.

6. The reliability of steroid receptor assays is paramount to their optimal use for the clinical management of breast cancer. Obtaining the proper tissue sample is of extreme importance and requires the cooperation of the surgeon, pathologist, and the assay laboratory. The following recommendations are made to people performing steroid receptor assays:

- The tissue sample should be immediately chilled to ice temperature, maintained at that temperature, and transported to the assay laboratory.

- A piece of the tissue sample directly adjacent to the piece for receptor assay should be sent to pathology for evaluation to insure that the sample to be assayed consists of tumor tissue.

- If the assay is not done on the same day, the tissue should be stored at -70°C or colder. Prolonged storage of tumor tissue prior to assay is to be discouraged.

- Currently, the most reliable and reproducible methods for cytosol estrogen receptor assay appear to be sucrose density gradient sedimentation analysis and multiple point dextran coated charcoal assay analyzed by Scatchard plot. As other methods appear, they should be validated against these methods.

- New techniques that localize receptor within tumor cells are desirable and may provide new or additional information. At the present time, no histochemical receptor assay can be considered validated and further work is needed to establish whether any such method has clinical usefulness.

7. There is a need for quality control of steroid receptor assays. To properly support the conduct of clinical trials in breast cancer, a quality control resource should be developed.

ANUSOL-HC®

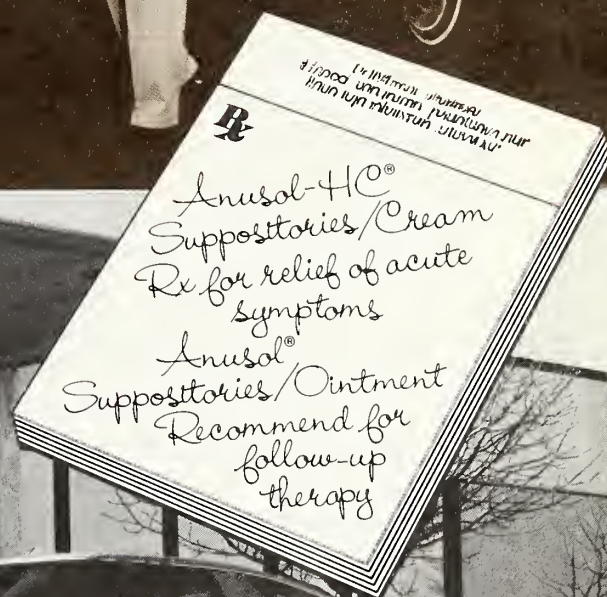
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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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2/80

There Isn't a Word for It

Ms.—An Irritating Abbreviation

A. W. CAVINS, M.D.
Terre Haute

In recent years, along with the advent of binary numerals, programming, and other such innovations in terminology to accommodate the electronic age, there has appeared an entity difficult to describe and impossible to define—at least, thus far. This has invaded the American language (I am uninitiated as to British English) on the crest of the great wave of women entering actively into the business world.

It is not a word but rather a term which in general seems to be used to indicate a woman, but without designation as to her social or socio-legal status, i.e., married, single (divorced, or otherwise), old maid or bachelor girl—in other words, a female person.

Since there is no single word to indicate a *female person* (because woman, girl, etc., are too specific), the difficulty has been glossed over by resorting to a symbol: **Ms.**

Don't Ms. Understand Me!

Do not be *Miss*-led by the *Ms.* I use;
It isn't exactly the title I'd choose.
It's really no more than a substitute
For the *M-r-s.* I'd like to toot!

—CORINNE BARITEAU

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For some, **Ms.** seems to mean *Bachelor Girl* in contradistinction to *Old Maid*, while others have adopted the use of **Ms.** to indicate, in a nice way, that they are divorcees. In addition, we have the Women's Liberators who began using **Ms.** to mean their sort of liberation (liberation from what not specified, although presumably from male porcine chauvinism).

Now all this is really unnecessary and very confusing, as well as embarrassing. **Ms.** or **MS.** has been used for centuries to mean Manuscript by authors, editors, librarians, teachers, preachers and anyone else with sufficient education to be interested in the production of literature or written records. Although it means, literally, "written by hand" it applies also to typewritten "manuscripts." Now we find it used to indicate females of the human race: in business letters, both at the head and the ending, on envelopes, in newspa-

pers and journals, so indiscriminately that, while we feel sure it means some kind of female person, it is impossible to say whether she is likely to be a *lady*, or a *woman* in general, or a *liberated woman*, or (most likely of all) a *divorcee*. Furthermore, if she is a divorcee, is this her married surname or the one she was born with?

It is impossible to pronounce **Ms.** as a word when used as a title because there has never been a word for the abbreviation to represent. This becomes a source of irritation to me, since when reading (even rapidly) I pronounce the words mentally, and **Ms.** is always a snag, thus giving me a bit of bias against *Ms. Smith* just because of the annoyance. I will venture that I am not the only one who has this little difficulty.

As to pronouncing *Miss* or *Mrs.*, the former is easy, being the full word, and the latter is derived from *Mistress*, the pronunciation having become slurred into *Missuz*. But how are we to approach **Ms.**? If we say *Miss* or *Missuz*, **Ms.** immediately becomes *Miss* or *Mrs.* and loses whatever particularity may have been intended.

Let me suggest that those who prefer a certain degree of anonymity and object to *Miss* or *Mrs.* could use the term *Female Person*, readily abbreviated to *F.P.* or *FP.* (I would prefer this to *Fp.* because the latter infers it is derived from one word.) Any female could use this without invasion of privacy, especially as to divorce.

Be that as it may, I will continue to grit my teeth slightly whenever I have to read *Ms. Sappho Smith*, whether under a signature or in newspaper—so help me! If there ever was an American abbreviation born out of wedlock, it must be **Ms.** Sad to say, there isn't a word for it.

GLOSSARY

- Woman**—generic term.
Lady—brand name; guarantee of quality.
Girl—child; if pubertal, could abbr. as *V* (equals virgin).
Adolescent—abbr. *CV* (equals Curious Virgin).
Miss—for years has meant unmarried; if past a certain age, could equal *Old Maid*.
Mistress—old term for married woman; standard abbr. *Mrs.*
Bachelor Girl—never married (as opposed to *Old Maid*, who has never been married, or anything).
Divorcee—formerly used as abbr. *Mrs.* or *Miss*, but now could use *DW* (which could mean Defensive Woman or Demoted Wife, according to who initiated the dissolution).
Business Woman—abbr. here still unsolved, since *BW* has become associated with Earl Wilson's Beautiful Wife.



THE INDIANA MEDICAL FOUNDATION, INC.
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A foundation for charitable, educational, and scientific purposes, organized by the ISMA as an endowment fund to support the educational mission of the Association and THE JOURNAL.

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The Foundation is managed by a board of directors that comprises the members of the ISMS Executive Committee. At present, proceeds from the Foundation investments are awarded to THE JOURNAL to further the continuing medical education program.

Memorial contributions made to the Foundation in lieu of flowers will be acknowledged by the secretary in a letter to the family of the deceased.

*"for religious, charitable, scientific,
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When systemic antifungal therapy must be instituted
even in compromised patients...

lack of nephrotoxicity makes Monistat i.v. the therapy of choice

TRADEMARK

With MONISTAT^{*} i.v. you can:

- **Start treatment early**
...without fear of kidney damage.
- **Continue treatment as long as necessary**
No renal damage has been reported in long-term use.
- **Treat again and again if needed**
No renal toxicity has been reported even in patients
receiving several courses of therapy.
- **Treat patients with pre-existing renal failure**
MONISTAT^{*} i.v. has not been reported to cause
further renal damage.


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Candida
albicans



Coccidioides
immitis



Paracoccidioides
brasiliensis



Cryptococcus
neoformans

Highly effective, improvement often seen within 1-3 weeks

Patients who do not respond or develop
resistance to amphotericin B
have responded to MONISTAT[®] i.v.

Resistance does not develop

In vitro resistance of clinical isolates
has not been reported during clinical trials.

Generally well tolerated by severely debilitated patients

Patients with cancer, those receiving
immunosuppressive agents, and patients
with serious underlying conditions,
such as diabetes mellitus or renal failure.

Photos courtesy of Dubos, R.J., Bacterial and Mycotic
Infections of Man, J.B. Lippincott Company, 1965 and
Burrows, W., Textbook of Microbiology, W.B. Saunders
Company, 19th edition.

Please turn page for Prescribing Information.



An important advance in
the treatment of systemic mycoses

Monistat i.v.

TRADEMARK

(miconazole)

broad-spectrum antifungal agent



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done

Broad-spectrum antifungal agent

Monistat i.v. (miconazole)

TRADEMARK



for intravenous infusion

DESCRIPTION: MONISTAT i.v. (miconazole), 1-[2-(2,4-dichlorophenyl)-2-[(2,4-dichlorophenyl) methoxy] ethyl]-1H-imidazole, is a synthetic antifungal supplied as a sterile solution for intravenous infusion. Each ml of this solution contains 10 mg of miconazole with 0.115 ml PEG 40 castor oil, 1.0 mg lactic acid USP, 0.5 mg methylparaben USP, 0.05 mg propylparaben USP in water for injection. Miconazole i.v. is a clear colorless to slightly yellow solution having a pH of 3.7 to 5.7.

CLINICAL PHARMACOLOGY: MONISTAT i.v. is rapidly metabolized in the liver and about 14% to 22% of the administered dose is excreted in the urine, mainly as inactive metabolites. The pharmacokinetic profile fits a three-compartment open model with the following biologic half-life: 0.4, 2.1, and 24.1 hours for each phase respectively. The pharmacokinetic profile of MONISTAT i.v. is unaltered in patients with renal insufficiency, including those patients on hemodialysis. The in-vitro antifungal activity of MONISTAT i.v. is very broad. Clinical efficacy has been demonstrated in patients with the following species of fungi: *Coccidioides immitis*, *Candida albicans*, *Cryptococcus neoformans*, and *Paracoccidioides brasiliensis*.

Recommended doses of MONISTAT i.v. produce serum concentrations of drug which exceed the in-vitro MIC values for the fungal species noted above. Doses above 9 mg/kg of MONISTAT i.v. produce peak blood levels above 1 µg/ml in most cases. The drug penetrates into joints.

INDICATIONS: MONISTAT i.v. is indicated for the treatment of the following severe systemic fungal infections: coccidioidomycosis, candidiasis, cryptococcosis, paracoccidioidomycosis, and for the treatment of chronic mucocutaneous candidiasis. However, in the treatment of fungal meningitis and urinary bladder infections an intravenous infusion alone is inadequate. It must be supplemented with intrathecal administration and bladder irrigation. Appropriate diagnostic procedures should be followed and MIC's should be determined.

MONISTAT i.v. should not be used to treat common trivial forms of fungal diseases.

CONTRAINDICATIONS: MONISTAT i.v. is contraindicated in those patients who have shown hypersensitivity to it.

WARNINGS: Rapid injection of undiluted MONISTAT i.v. may produce transient tachycardia or arrhythmia.

PRECAUTIONS: Before a treatment course of MONISTAT i.v. is started, the physician should make sure that the patient is not hypersensitive to the drug product. MONISTAT i.v. should be given by intravenous infusion. The treatment should be started under stringent conditions of hospitalization but subsequently may be given to suitable patients under ambulatory conditions with close clinical monitoring. It is recommended that an initial dose of 200 mg be given with the physician in attendance. It is also recommended that clinical laboratory monitoring including hemoglobin, hematocrit, electrolytes and lipids be performed.

It should be borne in mind that systemic fungal mycoses may be complications of chronic underlying conditions which in themselves may require appropriate measures.

JANSSEN PHARMACEUTICA INC.

501 George Street
New Brunswick, N.J. 08903
Attn: D.T. Mallegol

Please send me more information about the use of
MONISTAT i.v.™ (miconazole) in systemic candidiasis
and other systemic mycoses.

M.D.

Address _____

City _____ State _____ Zip _____

Specialty _____

March 1980

Pregnancy: Reproductive studies with MONISTAT i.v. in rats and rabbits revealed no evidence of impaired fertility or harm to the fetus. There are no data, however, on the use of the drug in pregnant women.

Children: Since the safety of miconazole i.v. in children under one year of age has not been extensively studied, its benefits in this age group must be weighed against the possible risks involved.

ADVERSE REACTIONS: Adverse reactions which have been observed with MONISTAT i.v. therapy include phlebitis, pruritus, rash, nausea, vomiting, febrile reactions, drowsiness, diarrhea, anorexia and flushes. In the U.S. studies, 29% of 209 patients studied had phlebitis, 21% pruritus, 18% nausea, 10% fever and chills, 9% rash, and 7% emesis. Transient decreases in hematocrit and serum sodium values have been observed following infusion of MONISTAT i.v. Thrombocytopenia has also been reported. No serious renal or hepatic toxicity has been reported. If pruritus and skin rashes are severe, discontinuation of treatment may be necessary. Nausea and vomiting can be mitigated with antihistaminic or antiemetic drugs given prior to MONISTAT i.v. infusion, or by reducing the dose, slowing the rate of infusion, or avoiding administration at mealtime.

Aggregation of erythrocytes or rouleau formation on blood smears has been reported. Hyperlipemia has occurred in patients and is reported to be due to the vehicle, Cremophor EL (PEG 40 castor oil).

DRUG INTERACTIONS: Drugs containing cremophor type vehicles are known to cause electrophoretic abnormalities of the lipoprotein. These effects are reversible upon discontinuation of treatment but are usually not an indication that treatment should be discontinued.

Interaction with the coumarin drugs resulting in an enhancement of the anticoagulant effect has also been reported. In cases of simultaneous treatment with MONISTAT i.v. and coumarin drugs, the anticoagulant effect should be carefully titrated since reductions of the anticoagulant doses may be indicated.

DOSAGE AND ADMINISTRATION:

DOSAGE

Adults. The doses may vary with the diagnosis and with the infective agent, from 200 to 1200 mg per infusion. The following daily doses, which may be divided over 3 infusions, are recommended:

Organism	Dosage Range *	Duration of Successful Therapy (weeks)
Coccidioidomycosis:	1800 to 3600 mg per day	3 to >20
Cryptococcosis:	1200 to 2400 mg per day	3 to >12
Candidiasis:	600 to 1800 mg per day	1 to >20
Paracoccidioidomycosis:	200 to 1200 mg per day	2 to >16

* May be divided over 3 infusions.

Repeated courses may be necessitated by relapse or reinfection.

Children. A total daily dose of about 20 to 40 mg/kg is generally adequate. However, a dose of 15 mg/kg body weight per infusion should not be exceeded.

ADMINISTRATION: MONISTAT i.v. should be diluted in at least 200 ml of fluid. The diluent of choice is 0.9% sodium chloride or alternatively Dextrose 5% injectable solution. The intravenous infusion should be given over a period of 30 to 60 minutes.

Generally, treatment should be continued until all clinical and laboratory tests no longer indicate that active fungal infection is present. Inadequate periods of treatment may yield poor response and lead to early recurrence of clinical symptoms. The dosing intervals and sites and the duration of treatment vary from patient to patient and depend on the causative organism.

OTHER MODES OF ADMINISTRATION: Intrathecal. Administration of the undiluted injectable solution of MONISTAT i.v. by the various intrathecal routes (20 mg per dose) is indicated as an adjunct to intravenous treatment in fungal meningitis. Succeeding intrathecal injections may be alternated between lumbar, cervical, and cisternal punctures every 3 to 7 days. Bladder instillation of 200 mg of diluted solution is indicated in the treatment of mycoses of the urinary bladder.

HOW SUPPLIED: MONISTAT i.v. is supplied in 20 ml ampoules.

MONISTAT i.v. (miconazole) is an original product of Janssen Pharmaceutica N.V., Belgium.



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done

THE JOURNAL offers its readers a Continuing Medical Education series of articles prepared by the faculty of the Indiana University School of Medicine. The program is coordinated and supported by a grant from the school's Division of Continuing Medical Education.

As an organization accredited for continuing medical education, the Indiana University School of Medicine certifies that this CME activity meets the criteria for one credit hour in Category 1 for the Physician's Recognition Award of the American Medical Association, provided it is used and completed as designed.

To obtain Category 1 credit for this month's article, complete the quiz on Page 177.



Initial Care of the Burned Patient

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Carbondale, Ill.
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Indianapolis
JAMES E. BENNETT, M.D.³
Indianapolis

A MAJOR THERMAL burn may have catastrophic medical, financial, and psychological implications. Since providing adequate care for severely burned patients can prove taxing to hospital facilities and per-

sonnel, many major burns are referred to centers specifically staffed and equipped for the management of burns. However, since most burns occur away from such centers, the initial evaluation and care

Do's and Don'ts of Initial Care of the Burned Patient

DO

- Start large intravenous line
- Insert urethral catheter and nasogastric tube
- Wrap in bulky absorbent dressings
- Arrange transfer to burn center

DO NOT

- Give narcotics intramuscularly, orally or subcutaneously
- Allow oral fluids
- Pack patient in ice
- Administer systemic antibiotics

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³Professor of Surgery and Director, Plastic Surgery Section, Dept. of Surgery, Indiana University School of Medicine.

of the patient is usually provided in the community hospital. After evaluation and the start of appropriate therapy, plans can be made for transfer to the nearest burn treatment facility.

The causes of burn injuries are many and vary primarily with patient age. Scald burns are usually seen in children under the age of 3 years. In the 4 to 15 year age group, flame burns are common and often associated with misuse of matches or open fires. Adults suffer burn injuries under varied circumstances, including industrial and automotive accidents, smoking in bed and unsafe use of gasoline. Ignition of clothing in any burn signifies a more severe injury and greater likelihood of full thickness burn.

Major burn injuries induce alterations in the normal physiology due in part to loss of the protective function of the skin. Under normal conditions, the skin acts as a barrier to invasive infection and impedes the loss of water and heat. Both of these functions are lost after a deep partial or full thickness burn injury. Insensible water loss and heat dissipation require tremendous energy expenditure to maintain body heat. Metabolic rate and caloric requirements increase correspondingly to maintain body heat and to offset massive catabolism.

EVALUATION

The severity of a burn injury (and implied prognosis) is determined by the extent and depth of the burn and the age of the patient. Other factors that influence prognosis are the location of the burns, associated inhalation injury, previous state of health and other trauma. The extent of the burn is expressed as a percentage of the total body area involved by the burn. An easy, rapid method for estimating the extent of the burn is the Rule of Nines. This establishes 11 areas, each consisting of about 9% of the total body

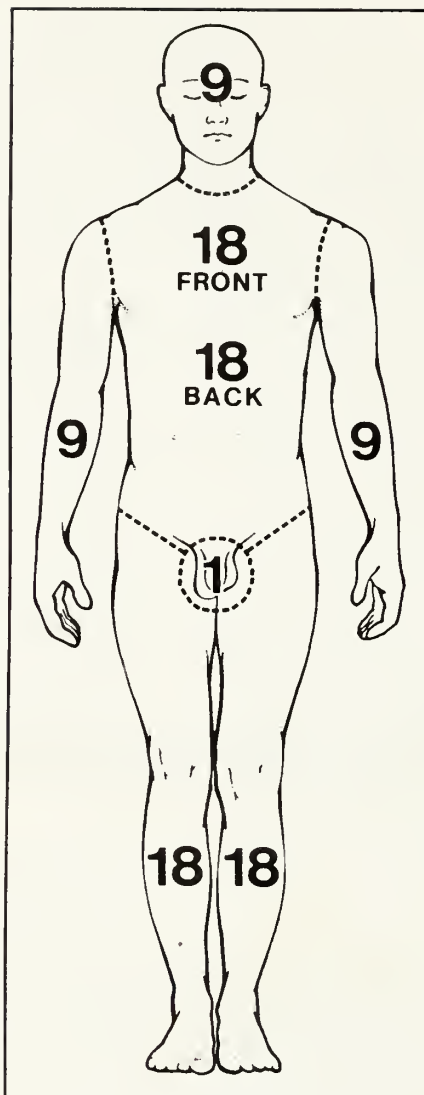


FIGURE 1
Rule of Nines for calculating total body burn percentage.

surface area in adults while the surface area of the head is greater and the legs are less in children under 4 years. These are:

	Children (under 4 yrs.)	Adults
Head	14%	9%
Trunk		18% front 18% back 9% each
Arms		
Legs	14% each	18% each

It is wise to evaluate the burned area first and establish a total body

burn percentage, after which one should calculate the unburned areas to confirm the previously established percentage. (Figure 1)

The depth of a burn is categorized as partial thickness or full thickness. The terminology first, second and third degree burn is not used as frequently as in the past. Partial thickness burns are further subdivided into superficial and deep categories. A superficial partial thickness burn is commonly the result of a brief exposure to the heat as in a scald burn. The burn is erythematous, with a uniform pink to red appearance. Blisters may remain intact; however, if they are broken, the surface is moist. Sensation is present and the burn is quite painful. Epidermal appendages (e.g., hair follicles) remain viable, and the burn heals spontaneously in 7-10 days.

Deep partial thickness burns are usually caused by flash explosions, brief exposure to flames or scalds in young children. The burn appears pink or white and is frequently mottled. The burns are moist but not excessively exudative. There is usually sensation to touch, and the burns may be painful. They heal spontaneously from the deeper dermal elements, primarily pilosebaceous units, in 14-21 days barring invasive infection.

Full thickness burn injuries are often caused by prolonged exposure to flame and ignition of clothing. The surface of the full thickness burn is usually dry and whitish or charred in appearance. The burned tissue is leathery in texture and has no sensation to touch and minimal pain. The underlying veins in the subcutaneous tissue can be seen and are frequently thrombosed. These full thickness skin losses ultimately require skin grafting for wound closure.

It should be remembered that the depth of burn is determined by the temperature of the agent, the time

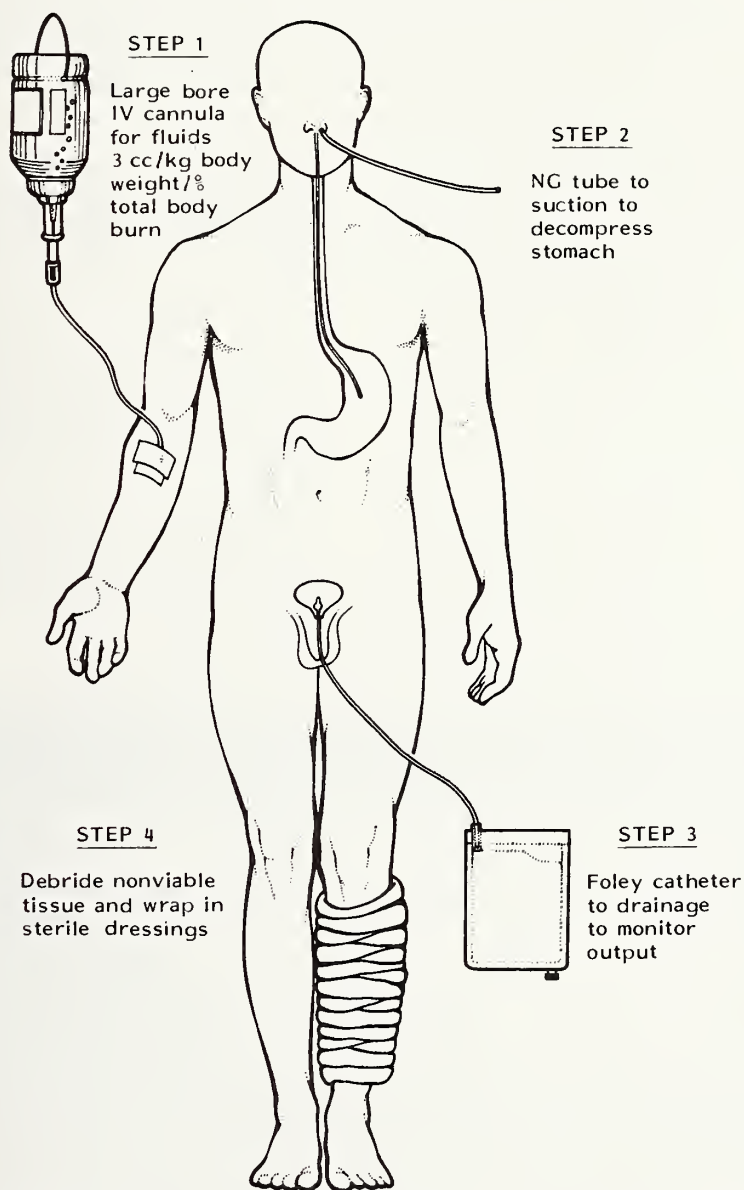


FIGURE 2
Four steps for initial care of burns.

INITIAL TREATMENT

After the patient and his injury have been evaluated, it is important that certain measures be taken expeditiously. In patients without respiratory distress or serious non-thermal injuries, the three important steps in initial management are to:

- 1) Insert a peripheral intravenous line for fluids,
- 2) Place a Foley catheter to monitor urinary output,
- 3) Insert a Levine tube and begin nasogastric suction.

A 16 or 18 gauge Intracath is recommended to allow administration of large volumes of balanced salt solutions required during the resuscitation phase. This may be inserted through burned skin if the underlying vein is patent. The Foley catheter allows monitoring hourly urine output to assess the adequacy of fluid resuscitation. Gastric distention and adynamic ileus occur as in any type of severe trauma and require gastric decompression to eliminate the risk of vomiting and aspiration en route. Nasogastric suction is continued until active peristalsis returns. Sterile bulky dressings are applied to the burn wounds to absorb the fluid and to minimize discomfort. (Figure 2)

During or after initial care of the patient, it should be decided whether to admit the patient to the hospital or transfer him to a burn treatment facility. Should the decision be that of transfer, the physician in charge of the patient's initial care should personally contact a physician at the burn treatment facility. After the patient is accepted, transport by ground or air is arranged. Patient comfort is enhanced by low flow humidified oxygen and covering the patient with blankets to prevent hypothermia during the trip. Packing the burned patient in ice is no longer recommended as the

of exposure or contact and the thickness of the skin. While burning agents of a moderate temperature (55-60° centigrade) usually produce partial thickness burns, prolonged exposure or contact (several minutes) may destroy the entire thickness of the skin. A baby (with very thin skin and rela-

tively little stratum corneum) may incur full thickness burns from hot water if the contact is sufficiently long. Very old people, with thin skin and a paucity of active epidermal appendages, may receive a full thickness burn in a circumstance where a younger individual would suffer only a partial thickness burn.

cooling causes peripheral vasoconstriction leading to decreased circulation to already compromised skin.

Remembering that the burned patient will, in the first 24 hours, require large amounts of intravenous fluids, such as lactated Ringer's, this intravenous solution should be started at a relatively fast rate. In the first 24 hours, a severe burn will generally require 3-4 ml. of fluid per kilogram of body weight per per cent of total body surface burn. Half of this amount should be given in the first eight hours. As an example, a 70 kg. patient with a 40% burn will require between 8½ and 10 liters of fluid in the first 24 hours.

Narcotics should be used sparingly. If indicated to control pain

(and not restlessness due to anoxia or extreme apprehension), they should be given in small increments intravenously — *never* subcutaneously, intramuscularly or orally. Unless the burn is a scald, we *do not* advocate the use of systemic antibiotics initially. Prior tetanus immunization should be checked and Tetanus Toxoid and Hypertet administered when indicated.

The burned patient is severely traumatized physically as well as emotionally. All who care for the patient initially must act with skilled reassurance to ease the patient's anxiety. Preventable complications of inadequate fluid resuscitation and aspiration of gastric contents must be avoided. Following the guidelines we have out-

lined, the burned patient should receive appropriate initial care and arrive at a burn treatment facility in the best condition possible.

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Acute Anterior Uveitis Secondary to Quinidine Sensitivity

DANIEL H. SPITZBERG, M.D.
Indianapolis

QUINIDINE IS A stereoisomer of quinine manufactured mostly from quinine. It is employed for cardiac arrhythmias and as an anti-malarial.

Quinidine is potentially dangerous, and deaths have occurred. In large doses, quinidine can cause a syndrome known as cinchoism. In the dosage generally used, the most common toxic manifestations are gastrointestinal. Diarrhea frequently occurs, but rarely, if ever, necessitates withdrawal of the drug. Idiosyncratic reactions, even to small doses, can occur. Usual symptoms are tinnitus, vertigo, visual disturbances, headache, confusion, skin rashes, angioedema, vomiting, cramps and diarrhea. Thrombocytopenic purpura occurs as a rare, but serious complication.

Other serious forms of hypersensitivity are indicated by respiratory embarrassment and vascular collapse: asthma, depression of breathing and even respiratory arrest. A precipitous fall in blood pressure associated with restlessness, vertigo, cold sweat, pallor and syncope characterizes the vascular collapse produced by the drugs.

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For more than a hundred years, quinine has been known to cause disturbances of vision. The effects of quinine have been rather uniform. The visual perceptive apparatus principally is affected. In the mildest disturbances, symptoms consist of slight clouding or flickering of vision and noises in the ears, accompanied by weakness and confusion. In more severe cases, there is a sudden, complete blindness, dizziness, tinnitus and partial deafness. In the most severe cases, there has been deep coma with circulatory collapse, followed by complete blindness, first evident when consciousness returns. As a general rule, central vision has recovered at least partially, but quite characteristically, a constriction of the peripheral field has remained permanently. The findings during the acute phase are that the pupils are dilated and unresponsive to light. In some cases, the retinal vessels have appeared narrowed early.

The principal controversy has been whether constriction of arteries is the primary effect causing damage to the retina, or whether narrowing of the arteries occurs secondary to the toxic effects of quinine directly on the retina. Either sequence could lead to atrophy of the optic nerve. Generally, the ERG has remained practically normal during first profound loss of vision. The ERG (electroretinogram) becomes grossly abnormal during the phase of beginning improvement of vision.

I am presenting here two cases of an allergic reaction to quinidine with acute anterior uveitis.

CASE REPORT #1

A 49-year-old physician who, on April 13, 1978, while jogging with his son had an acute collapse and was found to have ventricular fibrillation. He was defibrillated and stabilized and placed on quinidine, 300 mg. q.i.d. On May 13, he was readmitted with a fever of 103°, diffuse macular rash, and complete exfoliation of the external skin. During hospitalization he noted some injection of his eyes with some minimal light sensitivity, but because of the seriousness of his illness an ophthalmological examination was not performed.

I first saw the patient July 20, 1978, at which time he complained of blurred visual acuity and some redness to his eyes. Examination revealed 1+ conjunctival injection of both eyes; the cornea was clear. The right eye revealed 2+ fine keratic precipitates with a 1 flare 2 cell anterior chamber reaction. The left eye revealed 2+ fine keratic precipitates with a 1 flare 2 cell reaction. On the pupillary border, fine Koepple nodules were distributed in both eyes. Intraocular pressures were 16 mm of mercury in both eyes. The vitreous and retina were entirely normal.

The patient was started on prednisolone acetate, 1% solution q. hr. and dexamethasone 0.1% ointment at bedtime, and was to return in two weeks. At that time he said he was much improved, and his redness had completely disappeared. The inflammation also was decreased, and the keratic precipitates were gone. The corticosteroids were tapered, and he was again seen

Aug. 31, 1978. His anterior chamber inflammation had completely cleared, and topical steroid therapy was stopped. He underwent a coronary bypass operation Oct. 3, 1978, and when last seen Nov. 2, 1978, the anterior chamber reaction was minimal.

CASE REPORT #2

A 60-year-old white woman was admitted to the hospital Oct. 23, 1978. Ten days earlier she had been placed on 200 mg of quinidine, twice a day, for paroxysmal atrial tachycardia. Seven days after starting the medication, she developed a temperature of 103° and a red blotchy rash over the trunk of her body. She also described an "odd feeling" in her legs and an indifference in her personality. While she was in the hospital, her eyes became bloodshot. She was treated with bacitracin ophthalmic ointment, but there was no response.

She was first seen by me Nov. 16, 1978. The visual acuity in the right

eye was 20/20-2 and left eye 20/25. External examination revealed 1+ conjunctival injection. There was 1+ keratic precipitates in the right eye with a 1 flare, 2 cell anterior chamber grade. The left eye revealed 1+ keratic precipitates with a 1 flare, 2 cell grade. Intraocular pressures were within normal limits. However, there was an early posterior subcapsular cataract in the left eye. The vitreous was entirely clear, as was the retina. There were fine Koeppe nodules around the pupillary border of the iris.

The patient was started on prednisolone acetate, one drop to both eyes every two hours, and returned in two weeks. She was seen again Nov. 27, 1978; she felt that she was clinically better. Her examination was essentially improved with a 1 flare, 1 1/2 cell grade in the anterior chamber in both eyes. The prednisolone acetate was decreased to four times a day for 10 days and then stopped. She was last seen Dec. 28, 1978. Her visual acuity was 20/20 in the right eye and 20/

20-1 in the left with a flare, 0 cell in both eyes. Her anterior uveitis had completely cleared.

SUMMARY

I have presented here two patients with an anterior uveitis following a systemic reaction of quinidine therapy. Both cases presented the typical appearance of keratic precipitates, flare and cell in the anterior chamber, and Koeppe nodules. I know of no other cases of this type of allergic reactions to quinidine. We feel that it is important for ophthalmologists, cardiologists and internists to be aware of this possible association, as many of these patients are so sick from their general disease that the ocular involvement can be overlooked.

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Scientific Sidelight

Eating in Late Life

Aging processes are present in all people, although they do not necessarily progress at the same rate. For example, the cells that make up the muscle mass of the body diminish in number with advancing age. At 80 years of age it is estimated that one-half of the muscle cells remain. Obviously, despite continuing physical exercise, there is a reduction in muscle size and strength. As muscle cells disappear, they are replaced by fat and fibrous connective tissue. These cellular losses are not confined to voluntary muscles. In addition, there is a decline in heart cells. The loss of these cells from the conduction

system of the heart frequently result in cardiac arrhythmias.

It is estimated that the basic metabolic rate declines throughout the adult years, dropping some 16% from age 30 to 70 years. The caloric requirement drops even more because of decreased metabolism and the reduction in exercise. Consequently, if our body weight is maintained over several decades in late life, it is attributable to the accumulation of fat. Therefore, a gradual loss of weight is desirable after the age of 60 years.

Many changes are taking place in late life, including a decline in efficiency of renal function, a redistribution of body content with a decline in protein and an increase in fat, and changes within the nervous system, particularly gradual loss of neurons within the brain.

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Sandoz Prize Article*

SIDEROBLASTIC ANEMIA: Evaluation and Prognosis

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SIDEROBLASTIC ANEMIAS are a heterogeneous group of disorders representing approximately 1% of all anemic conditions.

The disease is characterized by abnormal iron metabolism associated with a refractory anemia and an abnormal erythrocytic precursor in the bone marrow. This abnormal precursor is a normoblast contain-

ing excessive amounts of mitochondrial iron arranged in a perinuclear distribution, the so-called ringed sideroblasts (*Figure 1*).

The increased mitochondrial iron is the result of faulty heme synthesis and not primarily a function of excessive metabolic iron.¹ Moreover, chemical characteristics of patients with sideroblastic anemia reflect an increase in total body iron as seen by an increased serum ferritin, serum iron, per cent transferrin saturation and general evidence of ineffective erythropoiesis.

Ineffective erythropoiesis is conveniently assessed by routinely available laboratory tests, such as increased LDH, increased bone marrow cellularity and decreased peripheral reticulocyte count.

Of significance in patients with sideroblastic anemia is the presence of two reasonably distinct populations of red blood cells in the peripheral smear: a relatively normocytic group of red blood cells, mixed with a less prominent microcytic and anisocytic population.

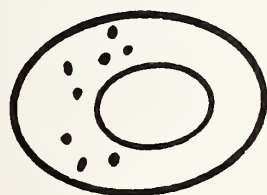
The ringed sideroblast may develop if there is an interruption of any one of three separate but crucially interrelated pathways leading to heme synthesis. These pathways are the iron metabolic pathway (*Figure 2*), Vitamin B₆ pathway (*Figure 3*), and porphyrin biosynthetic pathway (*Figure 4*).

These pathways converge within the mitochondria where the final steps of heme synthesis take place. The resulting ringed sideroblasts

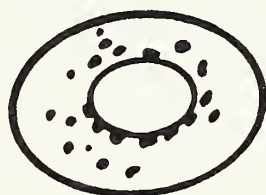
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*The monetary award presented to THE JOURNAL for having been selected a 1979 winner in the annual Sandoz Pharmaceuticals Medical Journalism Program is being used to fund publication of this article.



SIDEROBLAST



RINGED SIDEROBLAST

FIGURE 1

Diagrammatic representation of a typical sideroblast, contrasted with a ringed sideroblast.

may be readily visualized with appropriate iron stains. The resulting sideroblastic anemias may be classified into three reasonably distinctive categories: 1) Pyridoxine responsive, 2) Secondary forms (Figure 5), and 3) Primary or idiopathic.

Defects of the porphyrin rate-limiting enzyme step, Delta-aminolevulinic Acid Synthetase (ALA-S), accounts for the majority of sideroblastic anemias, both acquired and inherited. Abnormalities of other porphyrin biosynthetic enzymes have been described but are less well characterized.¹ The most common hereditary form of sideroblastic anemia is the so-called "hereditary pyridoxine-responsive sideroblastic anemia".²⁻⁴ As is presently understood, this is an x-linked disorder, characterized by microcytic, hypochromic red blood cells with the presence of numerous ringed sideroblasts in the bone marrow. The genetic alteration of this disorder is either an abnormality of the ALA-S enzyme (Enzyme A, Figure 4), or of the Vitamin B₆ pathway. Although many of these patients benefit from supplemental Vitamin B₆ therapy, few, if any, show evidence of a nutritional deficiency of this vitamin.

Current explanations of this disorder are less than satisfactory. If, in fact, the primary defect is in the ALA-S enzyme itself, it is hard to explain how large amounts of cofac-

tor can override an inherited enzymatic defect. There are, however, other inherited disorders in which high levels of pyridoxine exhibit such an effect. These conditions include pyridoxine sensitive seizures in children, xanthuremic

aciduria and cystathioninuria. Other less well characterized enzymatic defects resulting in sideroblastic anemia or the presence of ringed sideroblasts in the bone marrow include deficiencies of uroporphyrinogen I synthetase, uroporphyrinogen III co-synthetase, uroporphyrinogen decarboxylase, and coproporphyrinogen oxidase.¹

As seen from Figure 5, there are numerous conditions and drugs associated with secondary forms of sideroblastic anemia. The more common associations are with isoniazid (INH), lead poisoning and alcohol.

Isoniazid is known to cause sideroblastic anemia by condensing with the carbonyl oxygen of pyridoxal to form a hydrozone compound,

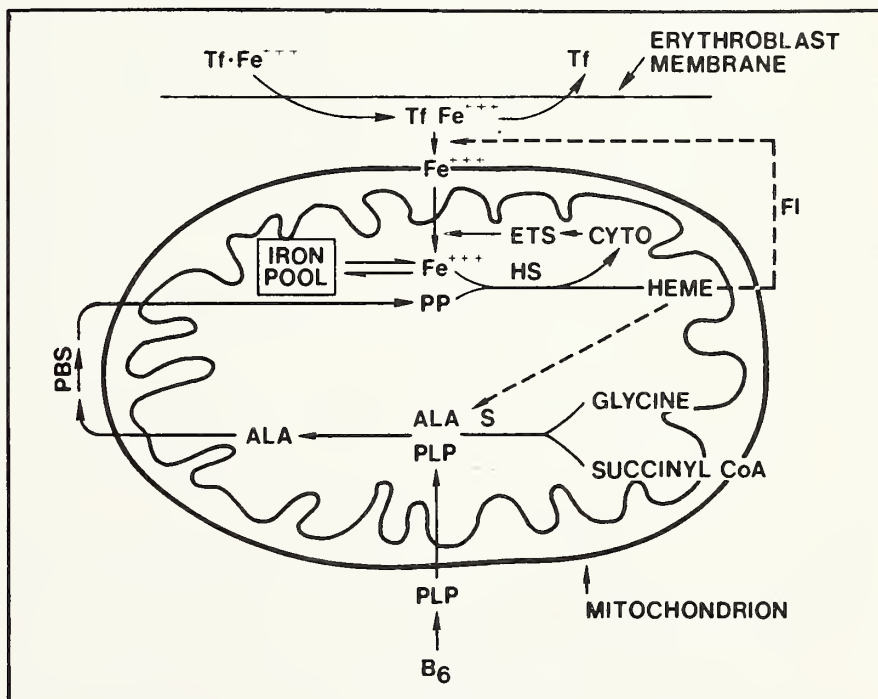


FIGURE 2

Representation of heme synthesis illustrating the interaction of iron, vitamin B₆, and porphyrin pathways. Tf represents transferrin; FI, proposed feedback inhibition loops; PLP, pyridoxal-5'-phosphate; ETS, electron transport system; CYTO, cytochrome system; ALA, delta-aminolevulinic acid; ALA-S, delta-aminolevulinic acid synthetase; HS, heme synthetase; PP, protoporphyrin; PBS, extramitochondrial porphyrin biosynthetic steps.

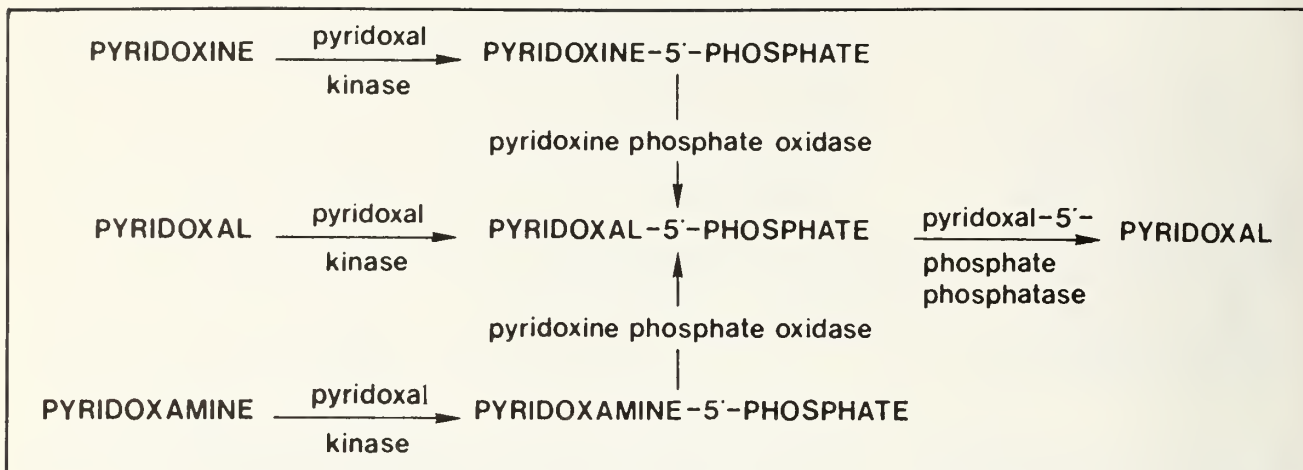


FIGURE 3
Representation of synthesis and degradation of pyridoxal-5'-phosphate.

which is a potent competitive inhibitor of pyridoxal kinase (*Figure 3*). Since a number of reported cases of sideroblastic anemia in patients on INH is relatively small, some have suggested there may be a genetic or nutritional factor that renders some people unusually susceptible to the actions of INH.⁵⁻⁷

Sideroblastic anemias also have been described in patients taking cycloserine, which is known to condense with pyridoxal, as well as directly inhibiting pyridoxal kinase.⁸ Although sideroblastic anemias have been described in patients on pyrazinamide, the mechanism remains obscure.

Although the incidence of accidental lead poisoning has fallen in recent years, it remains a common cause of sideroblastic anemia among children. Anemia is present in as many as 80% of patients with chronic lead poisoning.⁹ Both intramitochondrial and extramitochondrial enzymes steps of heme synthesis are inhibited by lead. Delta-aminolevulinic acid dehydrase (Enzyme B, *Figure 4*), is exquisitely sensitive to the effects of lead, and its inhibition results in increased urinary secretion of ALA. Heme synthetase (Enzyme G, *Figure 4*), the final step in heme synthesis, is

also affected by lead.

Alcohol induced sideroblastic anemias are unique in that there is complete remission following cessation of alcohol intake. Clinically, the course is marked by disappearance of the anemia with brisk reticulocytosis and disappearance of ringed sideroblasts from the bone

marrow.^{10,11} The primary effect of alcohol appears to be in the Vitamin B₆ metabolism. There is altered conversion of pyridoxine to its metabolic active counterpart, pyridoxal-5'-phosphate.

Interestingly, parenteral administration of pyridoxal-5'-phosphate is effective in ameliorating the ane-

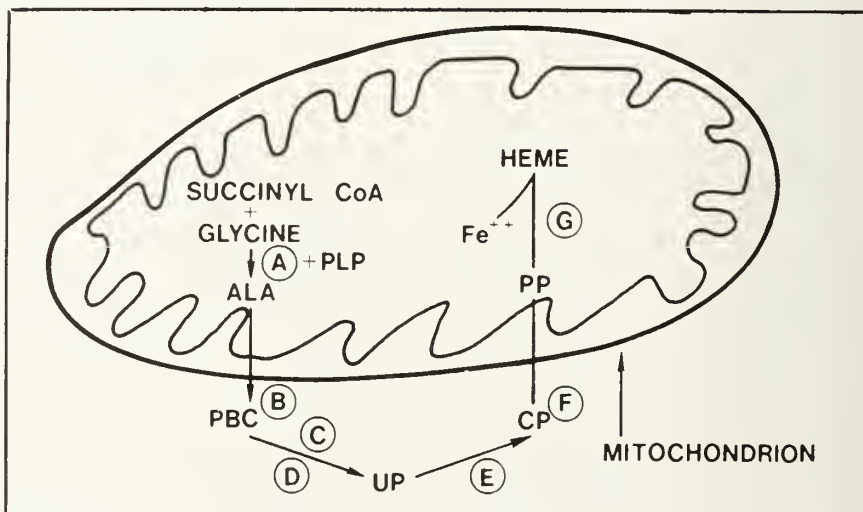
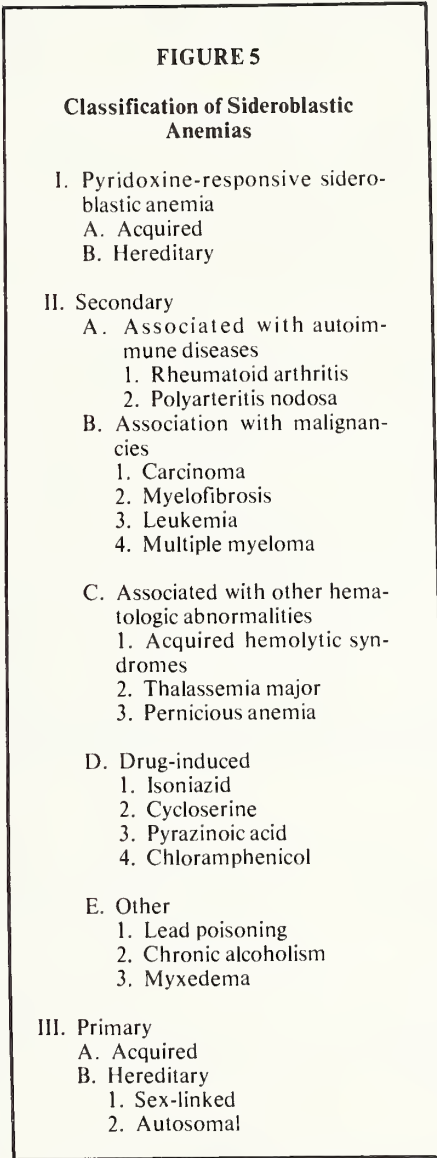


FIGURE 4
Heme biosynthesis, both intramitochondrial and extramitochondrial steps. A represents delta-aminolevulinic acid synthetase; B, delta-aminolevulinic acid dehydrase; C, uroporphyrinogen I synthetase; D, uroporphyrinogen III cosynthetase; E, uroporphyrinogen decarboxylase; F, coproporphyrinogen oxidase; G, heme synthetase (ferrochelatase).

mia, whereas even large doses of pyridoxine are not. Other evidence supports the hypothesis that acetaldehyde, a breakdown product of alcohol, accelerates degradation of pyridoxal-5'-phosphate by accelerating the enzyme pyridoxal-5'-phosphate phosphatase. These observations suggest that ultimately the effect of alcohol is exerted at the delta-aminolevulinic acid-phosphatase step, the most crucial pyridoxal-5'-phosphate dependent reaction. Also, the pattern of porphyrin accumulation in erythrocytes suggests the utilization of protoporphyrin is abnormal.¹² Moreover, high levels of ethanol have recently been shown to inhibit globin chain synthesis by some as yet unknown mechanism.¹³

The idiopathic variety of sideroblastic anemia presents an acquired anemia not associated with diseases, drugs or toxins. The anemia is not responsive to pyridoxine or other hematemic agents.¹⁴ Although there have been several case reports of decreased erythroblast delta-aminolevulinic acid synthetase activity, this finding alone does not seem to explain the anemia. In fact, the majority of patients with idiopathic refractory sideroblastic anemia do not have subnormal erythrocyte porphyrin levels at all. The normal to increased erythrocyte porphyrin concentration observed in most patients with idiopathic refractory sideroblastic anemia is more suggestive of faulty heme synthetase enzyme. With few exceptions, however, no abnormality of the heme synthetase enzyme has been demonstrated.

In addition to metabolic abnormalities, chromosomal alterations are not uncommon in patients with idiopathic refractory sideroblastic anemia. The most common of the abnormalities are of C-group chromosomes. This is of particular interest because a significant percentage of patients with idiopathic



refractory sideroblastic anemia go on to develop an acute leukemia, most often of the myeloblastic type.¹⁴ As has recently been learned, C-group abnormalities are not uncommon findings in patients with acute leukemias and myeloproliferative disorders.¹

Idiopathic refractory sideroblastic anemia occurs most often in patients in the sixth and seventh decades. Present data indicate there is no sex predilection. Symptoms most frequently include weakness,

dyspnea, and angina with exertion. Physical examination reveals pale skin and mucous membranes. In approximately 50% of the patients, the spleen tip may be palpable. Splenomegaly and hepatomegaly do not necessarily occur together, and marked increased size of either is rare. Peripheral lymphadenopathy is uncommon. Although reported in one case, dermal photosensitivity is not generally associated with this disorder.¹⁴

Laboratory features of patients with idiopathic refractory sideroblastic anemia include normocytic or slightly microcytic red blood cells. The hemoglobin level may on occasion be as low as 3 gm%, but more commonly is in the range of 7-10 gm%. Furthermore, one of the most striking features of the peripheral smear is the dimorphic population of red blood cells. There is usually a population of red blood cells that are hypochromic, with a mean corpuscular hemoglobin concentration low to low normal. Furthermore, the hypochromic red blood cells show marked anisopoikilocytosis. Occasionally, target cells, schistocytes and siderocytes may be observed. The reticulocyte count is generally within the normal range. Red blood cell osmotic fragility tests are usually normal but may be equivocal. The free erythrocyte protoporphyrin concentration in the majority of cases is normal to moderately increased and only rarely may be high. Serum folate levels have been reported to be low or low normal in approximately 75-80% of the cases.

The clinical course of most patients is protracted, lasting one to 10 years with an average survival from the onset of anemia of approximately five years. Death is usually a result of pneumonia, myocardial infarction, cardiac failure, or is attributable to some other concomitant disease. Increased susceptibility to infection is usually not

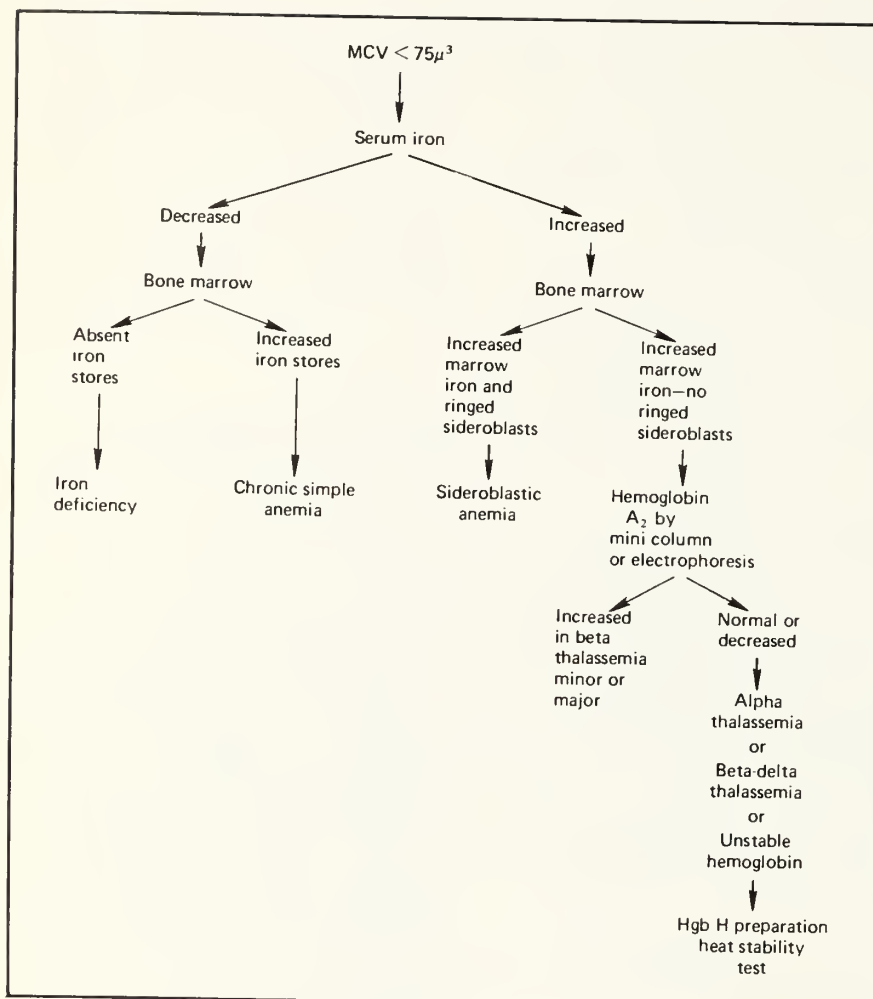


FIGURE 6
Suggested flow sheet for diagnosis of microcytic anemias.

a problem, and hemorrhagic manifestations are generally seen only in those patients in whom there is simultaneous thrombocytopenia. By definition hematemetic agents, such as supplemental iron, folic acid, Vitamin B₁₂, and even Vitamin B₆ are of little value in the idiopathic condition. Transfusion therapy inevitably becomes necessary in the majority of patients.

Until recently it was widely accepted that the inevitable outcome of idiopathic refractory sideroblastic anemia was the development of erythroleukemia or acute myeloblastic leukemia.¹⁵⁻¹⁶ Kushner, *et al* compiled data on 94 patients with sideroblastic anemia and found only seven patients with acute leukemia, an overall incidence of only 7.4%.¹⁴ The conclusion of Kushner's study was that not all patients with sideroblastic anemia are destined to develop leukemia; rather there exists a small group of patients who are more prone to undergo a leukemia transformation.

Information recently published by Streeter and Reinhard indicates that transformation of idiopathic sideroblastic anemia to acute leukemia is far more common in those

patients with concomitant thrombocytopenia.¹⁷ These authors reported a study of 17 patients with idiopathic refractory sideroblastic anemia in which 56% of the thrombocytopenic patients went on to develop acute leukemia, whereas only 7.4% of the patients with normal platelet count did.¹⁷ The ability to identify those patients who are more likely to undergo transformation to erythroleukemia or acute myeloblastic leukemia obviously would be of significant prognostic value. Although Streeter and Reinhard's data have yet to be confirmed by other researchers, their data appear statistically valid.

In summary, sideroblastic anemias constitute a heterogeneous group that may be characterized by either normocytic or slightly microcytic red blood cells (see Figure 6 for suggested diagnostic flow sheet). There are known to be multiple etiologies of sideroblastic anemia, all of which are characterized by impaired erythropoiesis, elevated levels of plasma and tissue iron, elevated transferrin saturation, and the presence of ringed sideroblasts in the bone marrow.

Sideroblastic anemias may be inherited or acquired but all are the result of abnormalities of one or more of three separate but interrelated biosynthetic pathways responsible for heme synthesis. The diagnostic cell in all forms of sideroblastic anemia is the so-called "ringed sideroblast." The cell is so named because of greatly increased amounts of mitochondrial iron, which may be readily demonstrated with appropriate stains. The iron-laden mitochondria are observed as a ring or a necklace about the nucleus of the bone marrow erythroblasts. Recent data suggest that concomitant presence of thrombocytopenia in patients with idiopathic refractory sideroblastic anemia may be of considerable prognostic significance.

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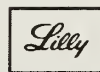
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Dermatology

CLINICAL NOTES

JERE D. GUIN, M.D.

Kokomo

Understanding Urticaria

The role of histamine in producing urticaria is well known, but factors modulating its synthesis and release have only recently come to light. The function of other mediators of inflammation in urticaria is poorly understood, even today. Histamine is manufactured in mast cells and basophils and released following either immunologic or nonimmunologic stimuli. These cells contain on their surfaces numerous receptors that act through cyclic nucleotides to shut down or facilitate the release of histamine. For instance, prostaglandin E inhibits histamine formation and release, and aspirin, therefore, aggravates it. A method of manipulating such modulators to the advantage of the patient was outlined in a previous article.¹

Much confusion exists regarding the role of H₂ blocking agents in urticaria. Theoretically, these agents should interfere with the normal feedback mechanism that shuts off histamine production. However, they also block H₂ vasodilatation, temporarily improving symptoms of the disease. Perhaps this is why several investigators found cimetidine beneficial in experimental urticaria where histamine is injected into the skin.² However, studies done on patients with chronic urticaria (where histamine production is endogenous) found no benefit for H₂ blocking agents.^{3,4} Histamine itself stimulates both H₁ and H₂ receptors on the surface of mast cells. Although this produces a threefold increase in cyclic AMP (the helpful one), it causes a fourteenfold activity in cyclic GMP (the harmful one).⁵ This is perhaps the reason chronic urticaria seems to continue without any obvious stimulus. I would infer from this that it is important to suppress histamine (H₁) activity and to continue this long after the patient is free of lesions.

Not well known is the finding that tricyclic antidepressants have both antihistaminic and antimuscarinic activity.⁶ Affinity for receptors in certain tissues may greatly exceed that of the more prominent antihistamines. Theoretically, doxepin (Sinequan®) should be useful in the treatment of urticaria since it has excellent affinity for both histamine and acetyl choline receptor sites in connective tissue. While there is no guarantee

receptor sites on mast cells and basophils will parallel those of other tissues, these studies lend credence to reports claiming benefits for tricyclic antidepressants in the treatment of urticaria.

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Botanical Dermatology

There are probably better places for book reviews than this column, which has traditionally emphasized treatment. However, I would like to call your attention to a much needed book that was recently published. *Botanical Dermatology* by Mitchell and Rook is the culmination of a 20-year project by John Mitchell of Vancouver, British Columbia, to summarize the literature on botanical causes of skin eruptions.

Information in the book has been classified in different ways to facilitate its use. The book is well indexed, and the botanical terminology is remarkably up-to-date. To my knowledge, it is the first publication of its kind and is, therefore, destined to be a classic. It would have been nice to have pictures of some of the plants for the benefit of non-botanists. However, this probably would have increased the price of the book, which is presently a bargain by anyone's standard.

REFERENCE

- Mitchell, John and Rook, Arthur: *Botanical Dermatology. Plants and plant products injurious to the skin*. 1979, Vancouver, B.C., Greengrass Ltd.

Salmonellosis in a Young Child

Unusual vector and atypical clinical course

HAROLD E. STADLER, M.D.
Indianapolis

THE SALMONELLA ORGANISMS have widespread distribution in nature, involving bodies of water, contaminated foods, rodents, and insects such as fleas and cockroaches. It is still probable that the most common transmission of the infection is by the human carrier. The unusual case report here involves *S. typhimurium*, which has been known to cause diarrhea in canaries.

CASE REPORT

A.T., a 17-month-old infant, was seen May 4, 1979. Diarrhea had been severe and progressive over a period of 10 days with passage of profuse green, watery and very mucoid movements at approximately hourly intervals. Vomiting had occurred during the last three nights of illness and may have been related to increasing acidosis. A weight loss of 2 1/2 pounds was noted.

Examination was negative except for the presence of moderate lethargy and skin dryness. Routine laboratory tests were normal except for ketones in the urine. Intravenous fluids were given and Septra® administered in the amount of one teaspoon each 12 hours. The clinical response was dramatic with rapid control of the diarrhea. The organism was shown to be resistant to ampicillin but sensitive to Septra®, which was continued for approximately 14 days. During the entire hospital course there was no fever, but stool cultures remained positive.

Since the entire family had remained healthy during this whole period, the family parakeet was investigated and found to harbor the identical organism. The parakeet, which was allowed to fly around the house, had evidenced no sign of illness. The patient is now clinically well, but protective techniques have been employed while serial stool cultures are evaluated for the carrier state. It is of interest that fever did not occur even with severe illness, and that Septra® controlled the diarrhea without clearing the stools of the pathogen.

From the Dept. of Pediatrics, Community Hospital of Indianapolis, Inc., 1500 N. Ritter Ave., Indianapolis 46219.

Tenuate® (C)

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of April, 1976

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Direct Medical Inquiries to
MERRELL-NATIONAL LABORATORIES
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Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Oillon], R.H. and Leyland, H.M. A comprehensive review of diethylpropion hydrochloride. In: Central Mechanisms of Anorectic Drugs, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404.

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**Overweight may not always be simple...
complications can develop.***

Complicated or not...

Tenuate[®] Dospan[®] [Ⓢ] **(diethylpropion hydrochloride NF)** **75 mg. controlled-release tablets**

A useful short-term adjunct in an indicated weight loss program.

Overweight patients in certain diagnostic categories often require strict appetite control and a successful program of weight reduction may tend to diminish the incidence or severity of the complications in some patients. Diethylpropion hydrochloride has been reported useful in such patients and while it is not suggested that Tenuate itself in any way reduces the complications of overweight, it may have a useful place as a short-term adjunct in a prescribed dietary regimen. **Tenuate should not be administered to patients with severe hypertension; see additional Warnings and Precautions on the opposite page.**

In uncomplicated overweight.

Many patients, on the other hand, present with excess fat but no disease. While this condition is often termed uncomplicated obesity, complications of both a social and a psychologic nature may be distressingly real for the patients. In these cases, a short-term regimen of Tenuate can help reinforce your dietary counsel during the important early weeks of an indicated weight loss program.

Clinical effectiveness.

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 16 separate double-blind, placebo-controlled studies attest to its usefulness in daily practice.¹ And the unique chemistry of Tenuate provides "...anorectic potency with minimal overt central nervous system or cardiovascular stimulation."² Compared with the amphetamines, diethylpropion has minimal potential for abuse.

**Tenuate—it makes sense.
And it's responsible medicine.**

*Studies have shown that obesity is associated with an increased incidence of hypertension, symptomatic heart disease, adult-onset diabetes, and other diseases.

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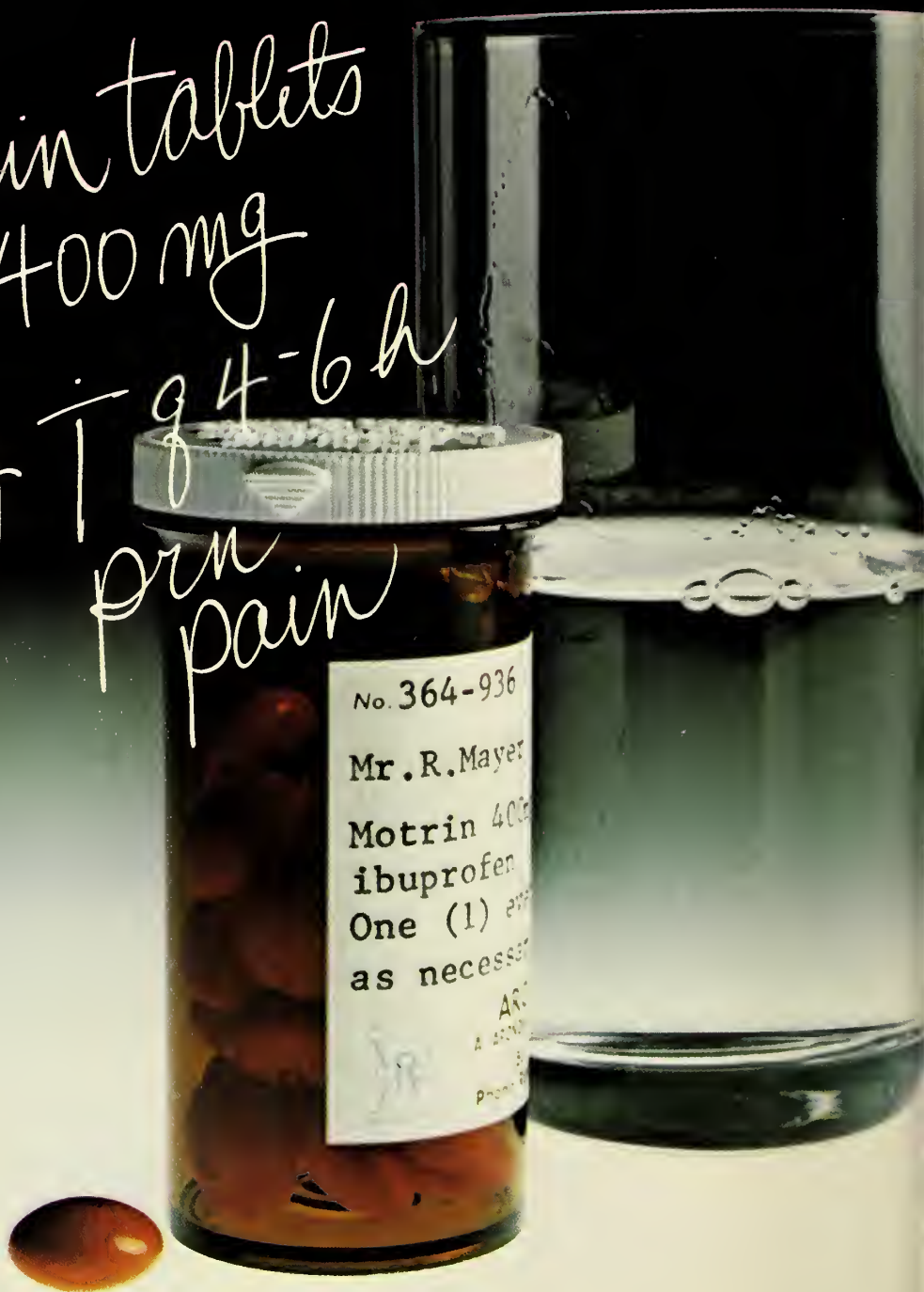


For prescribing information see opposite page.

A well-tolerated, nonnarcotic prescription for pain

Motrin tablets
400 mg

Sig T q 4-6 h
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pain



Motrin[®] now proved an effective analgesic for mild to moderate pain

Motrin 400 mg provided greater relief of pain than did propoxyphene 65 mg in controlled clinical pain studies.

Time after drug administration (hour)		.5	1	2	3	4
Mean relief-of-pain scores* (No. patients reporting)	Motrin 400 mg ibuprofen	.89 (108)	1.25 (108)	1.36 (108)	1.28 (107)	1.19 (106)
	Darvon 65 mg propoxyphene	.66 (100)	.99 (99)	1.13 (96)	.99 (96)	.80 (96)
Statistical significance		p<0.02	p<0.01	p<0.05	p<0.02	p<0.002

*0 = No relief 1 = Partial relief 2 = Complete relief

Data on file at The Upjohn Company

Motrin demonstrated statistically significant greater relief of pain than did Darvon at all time intervals.

Motrin 400^{TABLETS}mg

ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming
- Rapid analgesic action • Indicated in acute and chronic pain
- Well tolerated. The most common side effect with Motrin is mild gastrointestinal disturbance.

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin[®] (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin[®] Tablets (ibuprofen, Upjohn)

Indications and Usage: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. **Coumarin:** Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day.

Caution: Federal law prohibits dispensing without prescription.

For additional product information, see your Upjohn representative or consult the package insert.

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1980

SPRING: A NEW BEGINNING

BOOK REVIEWS

Labor and Delivery: An Observer's Diary — What You Should Know About Today's Childbirth

Constance A. Bean, with introduction by Gerald Cohen, M.D. Copyright 1977, Doubleday and Company, Inc. 203 pages, hard cover, \$7.95.

Some obstetricians might get the bends from reading this book, because parts of it will make their blood boil, and this is because a certain amount of bias will creep into this type of reporting (for a kind of newspaper reporting is what it is) even in book form. As, witness the incident reported on page 134 concerning the doctor's conduct of the third stage of labor, at a home delivery: "Again, 'Wait, Dr. Beck. Don't do that.' 'But I'm only trying to get the clots out. I *have* to do it,' he whined." I maintain the use of words such as "whined" is biased reporting, and while this type of thing is found only occasionally, the author is obviously not above it. She is, of course, an activist.

But let us not be blinded to the 99% excellent features of this work, written obviously for the lay public, but containing much upon which obstetricians would do well to ponder. Lawyers, especially those in legislatures, should ponder, too, since a not inconsiderable part of the routine hospital obstetrics complained of in this book is aggravated and kept going by the specter of malpractice suits in case Mother Nature is trusted too far.

The underlying theme of the book is *primam non nocere*; and with this I am in full agreement. I, being an oldtimer (a student under J. Whitredge Williams), am just as dismayed as she at Caesarean rates of 20% and the lack of training of young medicos in breech delivery, etc., etc. It is dismaying to be confronted with the stereotyped system used for obstetrical cases in so many hospitals. The mechanization of treatment, including monitors for normal cases, seems inhuman at times, yet who is Constance Bean to tell obstetricians how to do their work?

It seems to me she could have done the mothers (and thus, the babies) as much good and raised fewer doubts in their minds, by leaving out much of her psychological speculation about the doctors, and even some of it concerning the nurses, so that she could concentrate on informing the parents what to expect and (just as important) emphasize why various procedures are proposed and done. This approach would not in the least detract from her advocacy of home and/or "natural birth."

On the other hand, now that she has written the book the way it is, it would do physicians some good to read it, whether they get bubbles in their bloodstream or not, just to be apprised of the kind of "copy" they are inspiring. Robert Burns had the same idea with his "Oh, wad the power some giftie gie us. . . ."

A. W. CAVINS, M.D.
Terre Haute
Gynecologist

LETTERS

Attempts Underway to Clarify Medicare, Medicaid Confusion

CONTINUED FROM PAGE 138

is absolutely impossible in 100% of the facilities. The "overkill" syndrome enters into the picture in this aspect of surveys, and the amount of time lost from this nitpicking attitude is fantastic, disregarding the extensive expense. Surveyors need better instructions for consistency in doing their job.

Duplication of bureaucratic agen-

cy audits and surveys are a certain loss of time and money. Can't one or two teams be consistent and reliable enough to pass on the pertinent findings and make them available to authorized departments? Each audit or survey takes time from the medical director, director of nurses, administrator, and the Occupational Therapy, Physical Therapy and Activities Departments, as well as other departments. This is disrupting and detracting from patient care. The survey is absolutely necessary, but not so many of them. There seems to be a determination for one group to

find what the other group overlooked.

If some of these suggestions would be given serious consideration, the physician would be easier to entice to care for the aged, whether in his office or at a nursing facility.

ARVINE G. POPPLEWELL, M.D.
President, ISMA

ALBERT M. DONATO, M.D.
Chairman, ISMA Subcommittee
on Aging and Medical Directors
and Staff Physicians of
Nursing Home Facilities

BOOK REVIEWS

The Acute Abdomen For the Man on the Spot

J. C. Angell, F.R.C.S. Third Edition, Copyright 1979, Pittman Medical Publishing Co., Ltd., Kent, England. 116 pages, \$7.95.

Each young clinician needs a teacher at his side to give pearls of wisdom to guide him to right diagnostics and treatments while preserving him, like a guardian angel, from error. The intent of the author of this small soft cover book of surgical aphorisms in narrative form is to so advise the student of surgery.

The 10 chapter headings reflect this avuncular position of master to apprentice with examples such as "Personal Matters and Matters of Personality" (Chapter 1), "Appendicitis: Sense and Nonsense" (Chapter 5), and so on to the final epilogue called "The End: An Attitude?"

This is a fine little manual and useful reading for the abdominal surgeon—novice or hoary expert. The author has been forthright in reciting some of his own mistakes, that we may possibly avoid them ourselves. It is always edifying to see courageous medical attitudes in print in this age of forensic paranoia.

Every surgeon might benefit from a perusal of this small volume.

RODNEY A. MANNION, M.D.
LaPorte
Urologist

The Truth About Senility — And How to Avoid It

Lawrence Galton. Copyright 1979, Thomas Y. Crowell Publishers, New York. 244 pages, \$9.95.

A popularization of medicine needs a gimmick. This will incite the layman to purchase it and he will find a tangible benefit accruing from the book, which won't require a medical education to understand and apply. And so the title here titillates us with the prospect of understanding pathological old age and not succumbing ourselves.

There are chapters defining true old age, true senility or dementia, false dementia and then a myriad of more or less subclinical syndromes purported to be correctable. The intent is clear: Many, many so-called seniles aren't so at all, according to the author.

This might be true although improbable. The problem here is that the title is not, in my view, fulfilled by the text. How does one avoid senility if it's the real McCoy? No way, I'm afraid. Now, if the reader wants a self-help book to avoid inactive old age or to obviate the effects of a stupid doctor, this book will serve. It is a fund of up-to-date information on the treatment of disease in the aged and, as such, makes worthy reading.

RODNEY A. MANNION, M.D.
LaPorte
Urologist

There's a Word for It **CAUDA EQUINA**

RICHARD J. NOVEROSKE, M.D.
Evansville

The spinal cord doesn't extend all the way down to the sacrum; it ends in a trailing off of nerve roots at the level of L2; these nerve roots look like a horse's tail, and are called the *cauda equina*. I think this is a good term; it should be remembered, and probably used more often.

I see and hear many people speak of a herniated lumbar disc "pressing on the cord" or a lumbar puncture being dangerous because it might

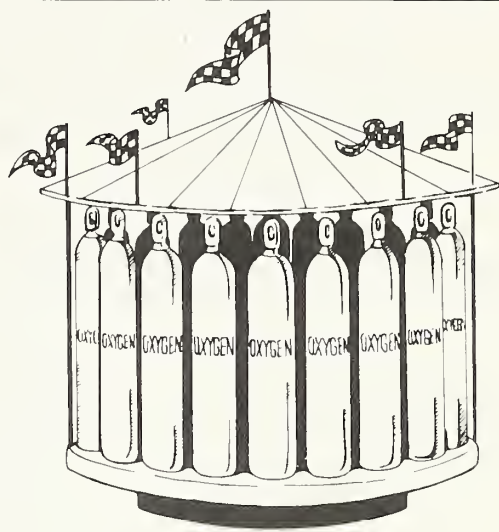
"injure the cord." The cord isn't present in the area of a lumbar puncture or a herniated lumbar disc; the brush-like *cauda equina* is, and this makes a difference. Probably much of the safety of a lumbar puncture is due to the ease with which these nerve roots can slide around the penetrating needle.

Let's not forget about the *cauda equina* and the help it gives us.



Attention Physicians:

Do You Have Patients On The Oxygen Cylinder Merry-Go-Round?



Oxygen Tank Deliveries
Also Available.

If you have patients using oxygen, call now for information on how they can get rid of those unsightly and inconvenient tanks. New oxygen concentrators make oxygen continuously out of the air in the patient's room, eliminates deliveries, and ends worry about ever running out of oxygen again. This marvelous new unit can even save money for patients who use more than 3 each H tanks per week. For more information on safe, continuous oxygen supply in the home call:

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96th & Meridian
Indianapolis, Indiana
Phone 1-317-844-8170

Route 14 at I-69
Ft. Wayne, Indiana
Phone 1-219-432-3321

Energy and Anti-Energy

Guest Editorial

L. A. ARATA, M.D.
Shelbyville

For several generations, our USA had all the coal and oil it could use, at prices that were the envy of the rest of the world. We were, in fact, a net exporter of coal and oil during part of that time. Our huge oil companies with their wells, refineries, and pipe lines provided all the petroleum products we could use with such efficiency that our retail prices were a fraction of the prices paid by consumers of most of the rest of the world. While doing this, they were able to make profits that were the envy of most other businessmen and politicians the world over.

Such efficiency could not be allowed to continue—so, enter the blighting hand of the Pirates of the Potomac with laws, and the Fuzzy Thinkers of Foggy Bottom with their bureaucratic rules, and we have our nation reduced to the pitiful condition of begging for the privilege of purchasing our needs at exorbitant prices from other parts of the world.

What better evidence of our own government's part in the energy mess do we need than a recent

Sunday night speech from our own Moses-come-down-from-the-Mountain President. He told us that we need to use more coal and less oil (a real mind-boggling statement) and favored creation of a new Bureaucratic Monster to cut through the red tape barriers preventing the mining and use of our vast coal resources.

Whence came these red tape barriers? Who erected them? Who is willing to fight to the death to maintain them? They were created by the Pirates of the Potomac in the usual way; by legislation leading to the mobilization of the vast armies of Fuzzy Thinkers to administer programs that were poorly thought out in the first place and impossible to administer in the second place. Now, the President wants to create another dragon to slay some of the existing ones.

It certainly would seem much more logical (and millions of tax dollars cheaper) for the Congress to forget its politics-as-usual attitude, and take on the job of slaying a few of its Congress-created bureaucratic monsters. That is a very unlikely thing to happen, since logic has rarely reared its beautiful head in the Halls of Congress—at least not in the 40 years that I have followed the national scene.

It would seem so much more logical to focus our national energy anger and disgust not on foreign nations, but on our own elected representatives in Washington who have caused our energy plight by their anti-energy laws and regulations. The blame belongs on Americans in Washington, and not on the Arabs.

1980-81 Membership Rosters

The 1980-81 ISMA membership roster goes on sale this month.

Handling this task for the first time is the Association's Membership Department; the roster previously was printed as a supplement to THE JOURNAL.

Paid subscribers to THE JOURNAL will be mailed a copy of the roster as soon as it is available, but it

will not be provided as a subscription feature in the future.

The Membership Department is selling the new roster for \$20 per copy. ISMA members, who will be sent a courtesy copy upon publication, may purchase additional copies for \$10 each.

To order, write Membership Department, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

Initial Care of the Burned Patient

CONTINUED FROM PAGES 153-156

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223.**

Multiple Choice—Choose the one best answer:

1. Deep partial thickness burns should heal spontaneously from:
 - a. wound edges
 - b. epidermal appendages
 - c. wound contraction
 - d. the basal layer of the epidermis
 - e. dermal fibrous elements
2. Preferred intravenous solution for acute burn resuscitation is:
 - a. whole blood
 - b. plasma or plasma substitute
 - c. physiologic saline
 - d. 5% dextrose in water
 - e. lactated Ringer's solution

True-False:

The burned child younger than 3 years differs from the burned adult in that:

3. Estimation of total burn must recognize larger head and smaller limb surface areas in the child.
4. The child is more apt to have a concomitant inhalation injury.
5. The child's skin is more resistant to damage from a given burning source.
6. Scald burns are more common in the very young child.

Initial care of a severely burned 30-year-old male should include:

7. Systemic antibiotics.
8. Urethral catheter.
9. Intravenous line.
10. Nasogastric tube.

Answers to the CME quiz that appeared in the January 1980 issue of THE JOURNAL: "Understanding the Sleep Apnea Syndromes," by Frederick A. Tolle, M.D.

- | | |
|----------|-------|
| 1. True | 6. c |
| 2. True | 7. c |
| 3. False | 8. c |
| 4. True | 9. a |
| 5. True | 10. b |

Answer sheet for Quiz: (Burned Patient)

- | | |
|---------------|----------------|
| 1. a b c d e | 6. True False |
| 2. a b c d e | 7. True False |
| 3. True False | 8. True False |
| 4. True False | 9. True False |
| 5. True False | 10. True False |

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of THE JOURNAL for my information.

Name (please print or type)

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Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this month's quiz, send your completed, signed application before Apr. 10, 1980, to the address appearing at the top of this page.

NEWS NOTES

Seventies: Health Improvements

The U.S. achieved notable health improvements in the 1970s, DHEW said in its annual report to Congress. The report shows a large decrease in the death rate in the past decade for males and females of all ages. The rate of death from heart disease dropped 17%. The infant mortality rate dropped from 20 per 1,000 to 14.1. Life expectancy at birth increased 2.3 years, from 70.9 to 73.2 years.

The report also says that low-income families had higher rates of physician visits than families earning \$25,000 or more, and that minority groups still trailed in many health categories.

Producer Price Index

The producer price index (cost to wholesalers of ethical pharmaceutical preparations) rose only 6.2% in 1979. In addition, the producer price index has risen only 45.2% since 1967, while the "all commodities" index has increased by more than 150%.

Valium Patient Information Test

Hoffman-LaRoche is conducting a six-month, in-depth test of two patient information systems for Valium. Valium patients in Atlanta, Boston and Dallas-Fort Worth will receive information on the drug, either via distribution of patient information sheets by pharmacists or by pharmacists' offers to patients of access to a new reference book containing patient information.

The survey will be expected to determine patients' interest in this information, their response and their comprehension of the information. Physicians' responses to the two methods also will be determined. The results will be shared with the FDA, which assisted in formulating the survey plan.

Kellogg Foundation Grants

The W. K. Kellogg Foundation has announced hundreds of grants for health, agriculture and education. In Indiana:

- \$764,500—awarded to Purdue University to develop and expand the statewide computerized communications system of the Indiana Cooperative Extension Service.

- \$34,328—awarded to Indiana Nurses Foundation, Inc., to develop a publication and visual presentation on involvement of statewide continuing education for nurses.

- \$74,424—awarded to Ball Memorial Hospital, Muncie, to prepare physicians for undergraduate and graduate teaching responsibilities in patient education and family medicine.

Finneran Endowment Fund

St. Vincent Hospital and Health Care Center, Indianapolis, has established The Joseph C. Finneran, M.D., Surgical Educational Endowment Fund in honor of Dr. Joseph C. Finneran, who is retiring as full-time chief of the Surgical Department at St. Vincent.

The fund was created in appreciation of Dr. Finneran's major contributions to surgical service at St. Vincent, his efforts in teaching, training and admissions program of Indiana University, his leadership in community medicine, and his role in the American College of Surgeons as one of its governors and as president of the state chapter.

Persons who wish to join in honoring Dr. Finneran and ensuring the perpetuity of this endowment may make checks payable to the St. Vincent Hospital Foundation, noting that the gift is for the Finneran Endowment. Mail checks to St. Vincent Hospital Foundation, 2001 W. 86th St., P.O. Box 40970, Indianapolis 46260, Attn: Finneran Endowment.



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SIDEROBLASTIC ANEMIA

CONTINUED FROM PAGES 160-166

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223.**

Multiple Choice—Choose the one best answer:

- The diagnostic cell of sideroblastic anemia reflects what?
 - Excessive total body iron
 - Transient absence of serum ferritin
 - Faulty intramitochondrial heme synthesis
 - Peripheral red blood cell destruction
- An increase in total body iron can be accessed by all of the following *except*:
 - Serum iron
 - Serum lactic dehydrogenase
 - Percent transferrin saturation
 - Serum ferritin
- The diagnostic cell of sideroblastic anemia results from the interruption of all of the following metabolic pathways *except*:
 - Vitamin B₆ pathway
 - Vitamin B₁₂ pathway
 - Iron metabolic pathway
 - Porphyryn biosynthetic pathway
- Therapy of the patient with sideroblastic anemia rests with which of the following?
 - Plasmapheresis of the excess iron
 - Maintenance of a high serum iron, since the increased body iron in this condition is not available for red cell production
 - Establishing the cause of the anemia if this is possible
 - Conclusions drawn from electron microscopic studies of the ringed sideroblast

- Which of the following is felt to be of significant prognostic value in patients with sideroblastic anemia?
 - The appearance of a diamorphic red cell population in the peripheral smear
 - A sudden decrease in the serum iron
 - Increased serum ferritin
 - Thrombocytopenia

True-False:

- The diagnosis of Sideroblastic Anemia is dependent upon demonstration of the so-called "ringed sideroblasts" in the peripheral blood smear.
- The ringed sideroblast is so named because of increased mitochondrial iron seen in a perinuclear distribution with appropriate iron stains.
- In one form or another, defects of Delta-aminolevulinic Acid Synthetase (ALA-S) account for the majority of Sideroblastic Anemias.
- Some patients with Sideroblastic Anemia respond to supplemental Vitamin B₆ therapy because most cases show a nutritional deficiency of this vitamin.
- It has recently been shown that most of the patients with Sideroblastic Anemia will ultimately develop erythroleukemia or myeloblastic leukemia.

Answer Sheet for Quiz: (Sideroblastic Anemia)

- | | |
|------------|----------------|
| 1. a b c d | 6. True False |
| 2. a b c d | 7. True False |
| 3. a b c d | 8. True False |
| 4. a b c d | 9. True False |
| 5. a b c d | 10. True False |

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this quiz, send your completed, signed application before Apr. 10, 1980, to the address appearing at the top of this page.

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of THE JOURNAL for my information.

NEWS NOTES



Gardner: 'Tell the Public We Care'

Dr. Hoyt D. Gardner urged physicians to "do more to show and tell the public how we care" during his presidential address at the AMA Interim Meeting.

Calling for a "human and social commitment from each physician," Dr. Gardner said, "Each of us must see himself or herself as the prime communicator of our profession in the one-to-one relationship with patients." He also stressed the need for physician cooperation in "good works" with the AMA Auxiliary and for greater community activity. "Voluntary local initiative or involvement has to be forthcoming for needs as diverse as health care planning, environmental safety, discipline within our profession, and containment of health care costs," he said.

M.D. Registration Fee Due Soon

The biennial registration fee for all licensed Indiana physicians is due in the office of the Medical Licensing Board of Indiana July 1, 1980. The fee for two years registration is \$40, payable by check or money order.

The Board will mail renewal notices to physicians in June. Physicians should notify the Board in advance of any address change. It is the physician's responsibility to pay the fee whether or not notice is received.

DHEW Blocked from Publishing Lists

Ruling that publication constituted "an unwarranted invasion of privacy," a U.S. District Court judge has issued a permanent injunction that blocks DHEW from publishing lists naming physicians and the amount of funds each received under the Medicare program. Covered in this injunction are lists released by DHEW since 1977.

FDA's Toll-Free Number

The Food and Drug Administration has a toll-free number for physicians to call to report problems with drugs, medical devices and in vitro diagnostic products. The purpose is to help the FDA determine when a product poses a significant potential health hazard.

Problems with which the FDA is concerned are hazardous or potentially hazardous products, mislabeling, incomplete or confusing instructions, erroneous information, non-sterile products, packaging errors, and other quality control errors.

The number to call is 1-800-638-6725.

Medicare Rule Clarified

A new Medicare rule, stating when a program beneficiary will have to pay for medical services that are not reimbursable by Medicare, appears to require that patients be given written notice by the provider (including physicians), the fiscal intermediary or the appropriate utilization review body when an item or service will not be paid by Medicare.

However, according to *Legislative Roundup*, sources in the Health Care Financing Administration point out that physicians in office practice will not be required to provide this written notice. The rule will apply only to providers of institutional services, the HCFA said.

Patient Package Inserts

FDA Commissioner Jere Goyan is quoted: "I am in favor of patient education. I am still considering whether or not I believe that patient package inserts are the most effective way of achieving that."

Record-Breaker for AMA-ERF

Indiana has broken all previous records with a total contribution of more than \$62,640 to the AMA-ERF during the 1978-79 period. The ISMA Auxiliary contributed more than \$28,930, while direct mail contributions accounted for \$11,270 and the ISMA, \$22,440.

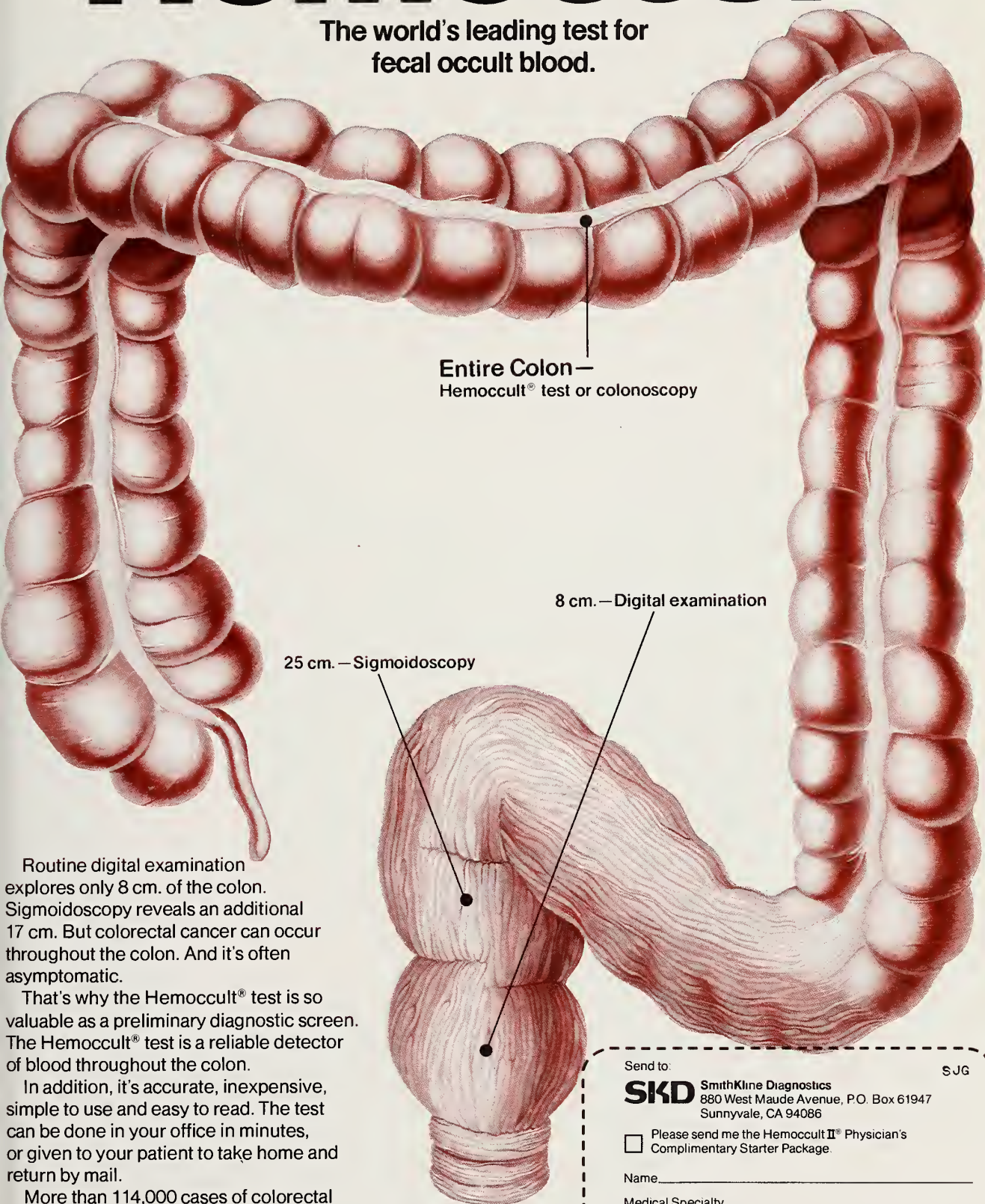
The figures were released by Charles Maciensi, executive director of the AMA's Education and Research Foundation.

Genetics Counseling Clinic

Memorial Hospital at South Bend is opening a Regional Genetics Counseling Clinic to serve northern Indiana and southwestern Michigan. The clinic will be a satellite service of the clinic at Indiana University Medical Center in Indianapolis and will offer diagnostic and counseling services in human genetics.

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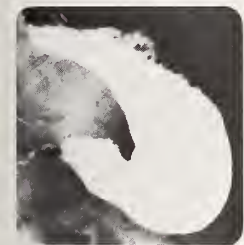
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In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



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"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia, urinary hesitancy and retention, blurred vision and tachycardia, palpitations, mydriasis, cycloplegia, increased ocular tension, loss of taste, headache, nervousness, drowsiness, weakness, dizziness, insomnia, nausea, vomiting, impotence, suppression of lactation, constipation, bloated feeling, severe allergic reaction or drug idiosyncrasies including anaphylaxis, urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons, and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. **Adults:** 1 tablet three or four times daily. Bentyl Injection: **Adults:** 2 ml. (20 mg) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanechol chloride USP) should be used.

Product Information as of October, 1978

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NEWS NOTES

Drug Lag Study

The University of Rochester's Center for the Study of Drug Development is now investigating the possible role of regulations in the drug lag. The Center has received a 30-month grant from the National Science Foundation for this purpose.

Marijuana Analysis

The National Institute on Drug Abuse and the Food and Drug Administration are holding meetings with a view toward determining whether marijuana and/or any of its ingredients possess therapeutic value.

The FDA has at least 29 investigational new drug applications for THC and marijuana therapeutic research. Studies are underway to determine the drug's efficacy for nausea and vomiting of cancer chemotherapy, intraocular pressure, spasticity of multiple sclerosis and other diseases, and anorexia and weight loss.

Hospital Elections

Huntington Memorial Hospital, Huntington—Dr. William A. Clunie, chief of staff; Dr. B. J. Krueger, vice chief of staff; Dr. William J. Webb, secretary.

St. Francis Hospital, Beech Grove—Dr. G. M. DeWester, president of the medical staff.

St. Catherine Hospital, E. Chicago—Dr. Vincent Santare, president of the medical staff.

Morgan County Memorial Hospital, Martinsville—Dr. Warren L. Gray, chief of staff; Kenneth E. Beaman, D.O., vice chief of staff; Dr. Robert E. Brubeck, secretary-treasurer.

Our Lady of Mercy Hospital, Dyer—Dr. Charles D. Egnatz, president of the medical staff; Dr. Jerome March, secretary; Dr. David A. Frieske, treasurer.

Community Hospital, Anderson—Dr. Frank Campbell, president of the medical staff; Dr. William J. Tierney, chief of staff; Dr. Paul L. Ramsey, vice president; Dr. Edson D. Carrel, secretary-treasurer.

Fellowships

American College of Physicians:

Dr. William R. Storer, Indianapolis.

American College of Chest Physicians:

Dr. Stephen J. Jay, Indianapolis

Diplomates

The following ISMA members have been named diplomates of the **American Board of Family Practice**:

Dr. Steven E. Ross, Fort Wayne;

Dr. Bart M. Saucelo, South Bend.

American Board of Obstetrics and Gynecology:

Dr. Loren J. Wanner, Bluffton.

Cancer Films Available

A new edition of the Descriptive List of Audiovisual Materials for Professional Education is now available from the Manager of Distribution, Indiana Division, American Cancer Society, 4755 Kingsway Dr., Indianapolis 46205.

Included in the list are such color motion pictures as "Blood Components in Cancer Therapy" (18½ minutes) and "Detection and Diagnosis of Cervical Cancer" (21 minutes). These and other audiovisuals are available on short-term loan free of charge and are available in 16mm and ¾-inch video cassette.

Here and There . . .

. . . A **Dr. Charles W. Dill** Memorial Fund has been established at Indiana Central University by medical associates, friends and neighbors of the Indianapolis physician, who died Dec. 6, 1979. Dr. Dill was team physician for the Indiana Central athletic program for 20 years.

. . . The former Dept. of Health, Education and Welfare (DHEW) is to be known as the **Dept. of Health and Human Services**. The change became necessary when President Carter signed legislation creating a separate Dept. of Education.

. . . **Dr. Harvey Feigenbaum**, professor of medicine at the I.U. School of Medicine, has received the American Heart Association's Richard and Hinda Rosenthal Foundation Award. One of the Association's Gold Heart Awards went to **M. Jeanne Pontious, R.N.**, associate professor, I.U. School of Nursing.

. . . **Dr. Louie O. Dayson** of Vincennes, director of cardiology and chief of medicine at Good Samaritan Hospital, has been named a member of the board of directors of a Vincennes bank. He recently received Vincennes University's Outstanding Alumni Award and the Walter Davis Award.

. . . **Dr. William M. Mount** of Lafayette has been named chairman of the Committee on Credentials of the American College of Allergists.

. . . **Dr. Frank Vinicor**, an associate professor at the I.U. School of Medicine, has been named president of the Indiana affiliate of the American Diabetes Association. He was a guest speaker during the scientific session of last fall's ISMA annual convention.

. . . **Dr. Wilson L. Dalton** of Shelbyville has been reappointed to the Indiana Medical Education Board. The board recruits medical school graduates for the state and boosts the education of graduates in family practice.

. . . **Dr. Martin E. Feferman** of South Bend, **Dr. John B. White** of Indianapolis and **Dr. William K. Nasser** of Indianapolis have been appointed to the Indiana Medical Advisory Commission on Driver License.

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OBITUARIES

Russell J. Baskett, M.D.

Dr. Baskett, 74, a general practitioner in Jonesboro 47 years, died Jan. 17 at his home.

He was a 1933 graduate of the Indiana University School of Medicine and was a World War II Army veteran.

Dr. Baskett, a senior member of the ISMA since 1976, was a member of the American Academy of Family Physicians.

Richard C. Minczewski, M.D.

Dr. Minczewski, 59, a Merrillville physician, died Jan. 6.

He was a 1944 graduate of the Indiana University School of Medicine.

Dr. Minczewski was a member of the American Academy of Family Physicians.

Robert D. Spindler, M.D.

Dr. Spindler, 71, Cedar Lake, a retired Shelbyville physician, died Jan. 29 in Cedar Lake.

He was a 1934 graduate of the Indiana University School of Medicine and was an Army veteran of World War II.

Dr. Spindler was a former president of the Shelby County Medical Society.

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George D. Joslin, M.D.

Dr. Joslin, 39, staff psychiatrist at the Mental Health Center, Fort Wayne, died Jan. 7 in Phoenix, Ariz., where he was vacationing.

He was a 1971 graduate of the Indiana University School of Medicine. Previously, he had been a school teacher in Elkhart.

Dr. Joslin was a member of the American Psychiatric Association, the Indiana Psychiatric Society and the Fort Wayne Mental Health Association.

I. C. Hernandez Silverman

Dr. Hernandez Silverman, 60, an East Chicago physician since 1952, died Jan. 14 at St. Joseph Hospital, Chicago, as a result of injuries sustained in an automobile accident.

A native of the Philippines, she received her M.D. degree from the University of Santo Tomas in 1942. She was a member of the American Academy of Family Physicians.

H. Vaughn Scott, M.D.

Dr. Scott, 72, a Fort Wayne pediatrician for 37 years, died Jan. 22 at his home.

He received his M.D. degree from Northwestern University in 1934. After retiring from private practice, he practiced at the Fort Wayne State Hospital and Training Center.

Dr. Scott, a veteran of World War II, was certified by the American Board of Pediatrics.

Evered E. Rogers, M.D.

Dr. Rogers, 70, an Auburn physician and surgeon for 32 years, died Jan. 25 at DeKalb Memorial Hospital.

He was a 1943 graduate of the Indiana University School of Medicine and was a veteran of World War II.

Dr. Rogers had served 20 years as DeKalb County Health Officer and was a former president of the DeKalb County Medical Society.

James T. Oswalt, M.D.

Dr. Oswalt, 66, a Bedford physician, died Jan. 13 at St. Vincent Hospital, Indianapolis.

He received his M.D. degree from the University of Arkansas in 1939. He served in New Guinea during World War II and was a staff physician for the Indianapolis VA from 1945-48.

Dr. Oswalt practiced in Mitchell until 1963, when he joined the Edgewood Clinic in Bedford. He was a member of the American Academy of Family Physicians and was a former president of the Lawrence County Medical Society.

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3.	Francis H. Gaatee, Jasper	Charles X. McCalla, Paali	April 11-12, 1980, Jasper
4.	Mark M. Bevers, Seymour	Harry R. Baxter, Seymour	May 14, 1980, Seymour
5.	Rahim Farid, Brazil	Clyde Jett, Seelyville	May 28, 1980, Brazil
6.	James M. Larber, Shelbyville	William F. Kerrigan, Cannerville	May 7, 1980, Cannerville
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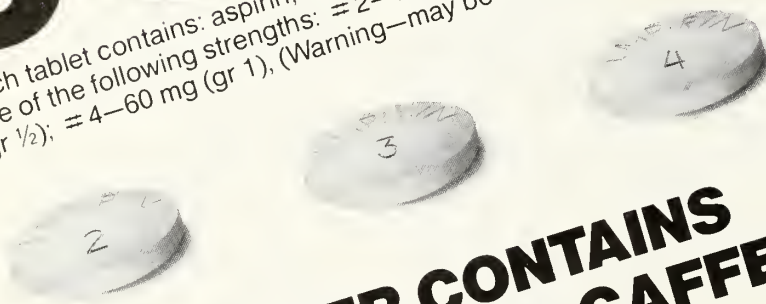
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PHYSICIAN WANTED for locum tenens or association in clinic. Family physician or ABFP physician starting on or before April 1, 1980 and to July 1, 1980 or longer if mutually agreeable. Delightful, thriving county, new hospital, 24-hour paid ER coverage. Excellent x-ray and lab departments. Well qualified specialist staff for consultations and referrals. All physicians are friendly and helpful. No major surgery; minor surgery and OB optional on mutual basis. I would work with male or female physician for at least the first two weeks steady, then return briefly at intervals, then return full time most of June. The community needs at least 2 or 3 ABFPs and I can help them become established in practice in any type of work they prefer. The clinic is a satellite of Cameron Hospital and itself has excellent full lab and x-ray facilities. The remuneration is negotiable. Contact John J. Hartman, M.D., FICS, Inc., Elmhurst Clinic, 909 W. Maumee, Angola, Ind. 46703. Office phone (219) 665-2263, home phone (219) 665-2559.

FULL TIME POSITION as Emergency Room Physician in 365-bed hospital. Salary competitive. Contact Ralph D. Weller, M.D., Emergency Department, or Mr. Les Rankin, Associate Administrator, Lafayette Home Hospital, Inc., 2400 South St., Lafayette, Ind. 47904. Tel: (317) 447-6811.

PONTE VEDRA, FLORIDA—2 villas for rent: Beautifully furnished two and three bedroom condominiums adjacent to golf course and tennis courts; short walk to the beach. At Sawgrass, home of Tournament Players Championships March 17-23. Long or short terms available at reasonable rates. Call (812) 479-8571 or (812) 477-9933.

MADISON, INDIANA—Large, established practice available in near future in beautiful, thriving southern Indiana community. I am retiring, having been in the same location for 40 years. Large office space available. Office equipment and furnishings valued at \$20,000. Will sacrifice at reasonable fee. Wm. A. Shuck, M.D., 414 N. Mulberry St., Madison, Ind. 47250. Tel: (812) 265-3854.

EMERGENCY MEDICINE—Central Illinois: One director and two staff opportunities in a 250-bed hospital emergency room serving approximately 10,000 patients annually. University community just 125 miles from Chicago and Indianapolis, 175 miles from St. Louis. Excellent minimum guarantee, 48 hours per week/48 weeks per year, professional liability insurance provided. For details, submit credentials in strict confidence to Rena Ballard, 970 Executive Parkway, St. Louis, Mo. 63141, or call toll-free 1-800-324-3982.

THERE IS GREAT practice opportunity for doctors interested in Internal Medicine, Pediatrics, OB, Urology, Pulmonary, Cardiology, Dermatology, Orthopedics, Rheumatology, Allergy, Endocrinology, GI and Family Practice. In Lafayette, Ind., home of Purdue University. If interested, please write Marvin Smitherman, 2323 Ferry St., Lafayette, Ind. 47904.

NEEDED: Staff physician, general practice. Must be medical school graduate and eligible for Indiana license. \$45,000 annual guarantee plus private office (furnished), 40 hours minimum (to vary) per week. Contact Andrew J. Barrett, II, Executive Director, Adams County Memorial Hospital, 805 High St., Decatur, Ind. 46733. Tel: (219) 724-2145.

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Trauma Care Symposium June 7, 1980

University of Health Sciences/The Chicago Medical School is pleased to announce a symposium on "Changing Concepts in Trauma Care" to be held on Saturday, June 7, 1980, at the Marriott Lincolnshire Resort, a suburb of Chicago.

The program is accredited for 8 hours in Category I for the Physicians Recognition Award of the American Medical Association.

A distinguished faculty from leading universities in the country will participate in the symposium. Ample time for pre- and post-tests and question and answer sessions has been allotted.

The registration fee is \$100 for physicians, \$50 for residents, nurses and paramedical personnel. The fee includes a luncheon with the faculty.

For further information, call Miss Christine Chiaramonte #312-770-2243 or Dr. Sriram #312-770-2000 or write to Miss Chiaramonte at Saint Mary Hospital, Room 1043, 2233 West Division Street, Chicago, Illinois 60622.

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March 1980

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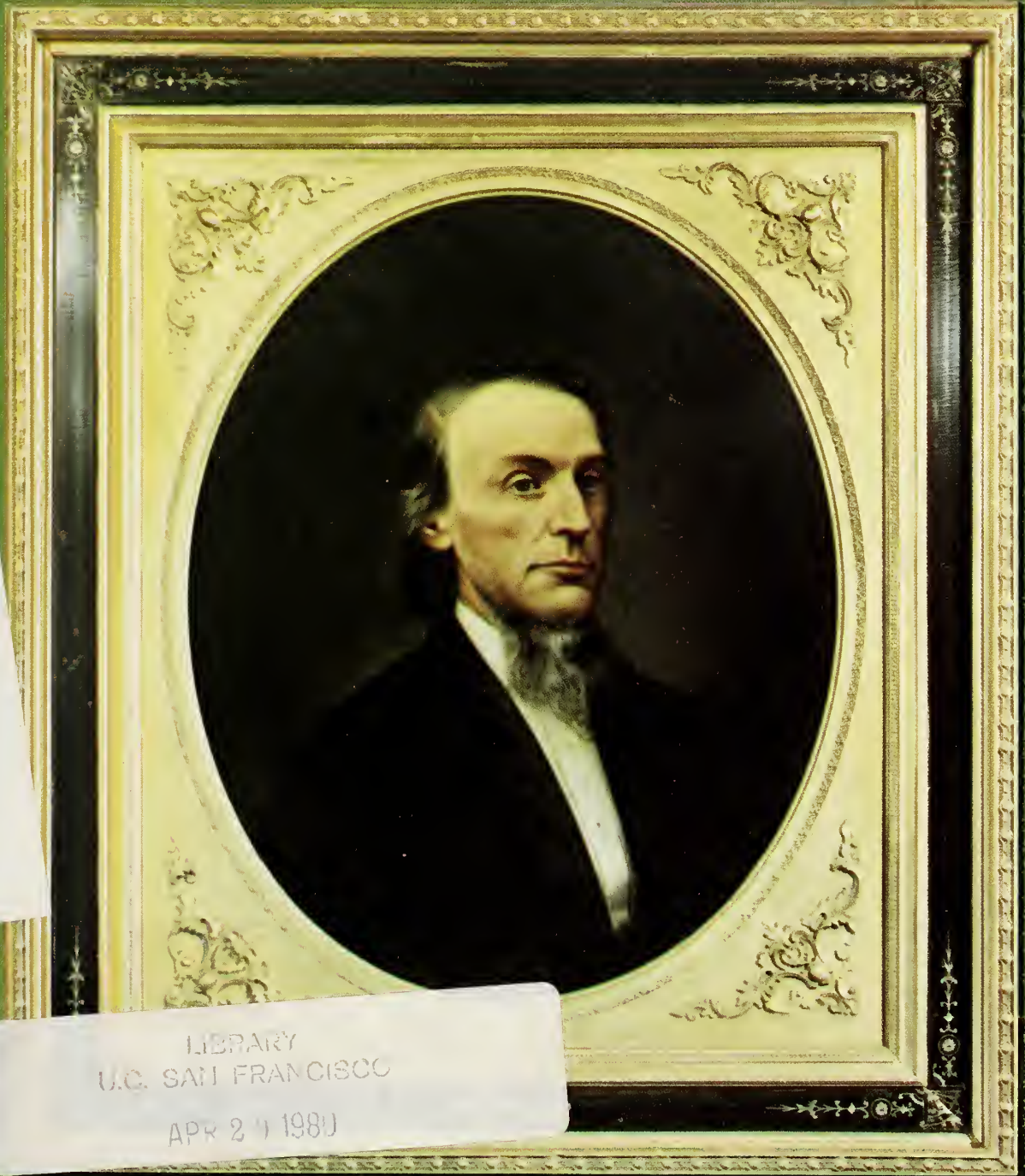
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The JOURNAL

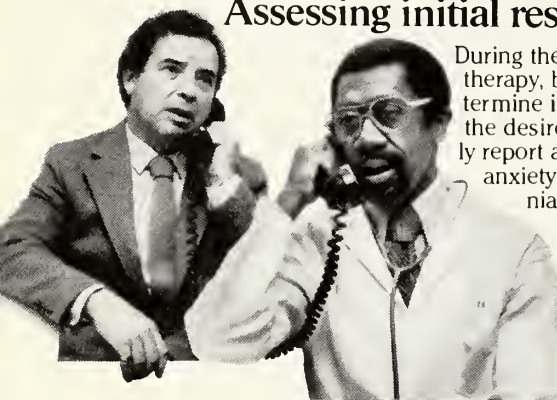
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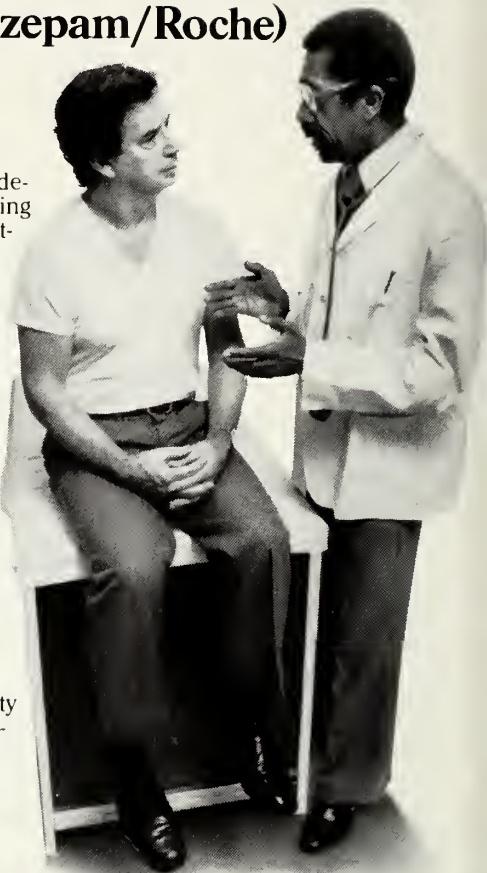
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- **JOHN STOUGH BOBBS, M.D. (1809-1870)**
World's First Gall Bladder Surgeon: A Hoosier
 - **OUTPATIENT TREATMENT OF ASTHMA IN CHILDREN**
A Continuing Medical Education Article

Monitoring patient response to Valium® (diazepam/Roche)

Assessing initial response to therapy



During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

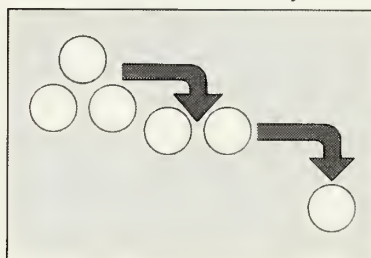
Evaluating progress toward therapeutic goals

SET GOALS						
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
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At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

2-mg, 5-mg, 10-mg scored tablets
Valium®
 diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety

Valium® (diazepam/Roche) ®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; atetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.


Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria; jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d., adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10; Prescription Paks of 50, available in trays of 10.

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BURROUGHS Business Forms Division offers a WRITE-IT-ONCE® accounting system for doctors. One writing creates a charge ticket, updates the patient's statement and ledger card, posts the daily record of charges and receipts, and prepares a bank deposit slip. The system reduces clerical posting time by as much as 75%. All the forms are carbonless and produce clear copies without smudge.

SQUIBB is marketing Corgard®, a beta-blocker that requires only once-a-day dosage for treating either hypertension or angina. Corgard has a half-life of 20 to 24 hours and is able to maintain an effective blood level on one daily dose. Squibb reports that it is well tolerated and is well absorbed in the presence or absence of food. It has been approved for marketing in 23 other countries.

LILLY announces the marketing of a new purified pork insulin, Iletin® II, Pork. The new product (available in Protamine, Zinc; Regular; NPH; Lente; and Regular, Concentrated) will be gradually phased-in as the supplies of the current Lilly pork insulins are exhausted. Physicians and pharmacists are being advised that some patients may need a change of dosage when switching to the new product.

C. V. MOSBY COMPANY announces publication of the 4th edition of *Lawton and Foy's Textbook for Medical Assistants*. Donald Foy, executive director of ISMA, and Dr. Lowell Thomas of Indianapolis are co-authors with M. Murray Lawton, M.D., administrator, The Berkley School, and Victor Schrammske, Red Cross certified CPR instructor of Bloomington, Minn. The 550-page book contains 150 illustrations; it covers a myriad of subjects with which medical assistants should be expert. Mosby also is publishing a new book, *Workbook for Medical Assistants*, which is coordinated with Lawton and Foy's textbook.

THE POLAROID CORPORATION announces a new supplement to their *Close Up* magazine. The first issue of the new supplement is devoted to the new trends in medical imaging with the use of Polaroid instant photography. The 16-page booklet is titled *Focus*. It is available free of charge by writing to *Focus*, c/o Polaroid, 549 Technology Square, Cambridge, Mass. 02139. The first issue illustrates many striking examples of photographic reproduction for a variety of purposes. It also lists specialized film packs and the medical uses for which each type of film is best suited.

CONTINUED ON PAGE 204

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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POSTMASTER: Send address changes to THE JOURNAL, Indiana State Medical Association, 3935 N. Meridian St., Indianapolis, Ind. 46208.

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Advertising rates and data available on request. Representative for national advertising: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302.

Publication deadline: 1st day of month preceding month of issue.

Subscriptions: \$14 per year, USA; \$16, Canada; \$17, foreign; \$12, libraries; \$10, senior ISMA members; \$8, members; except for special issues, single copies not available. Subscriptions renewable only in January and July.

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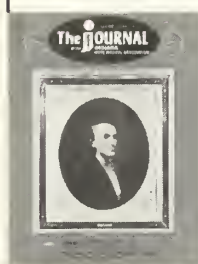
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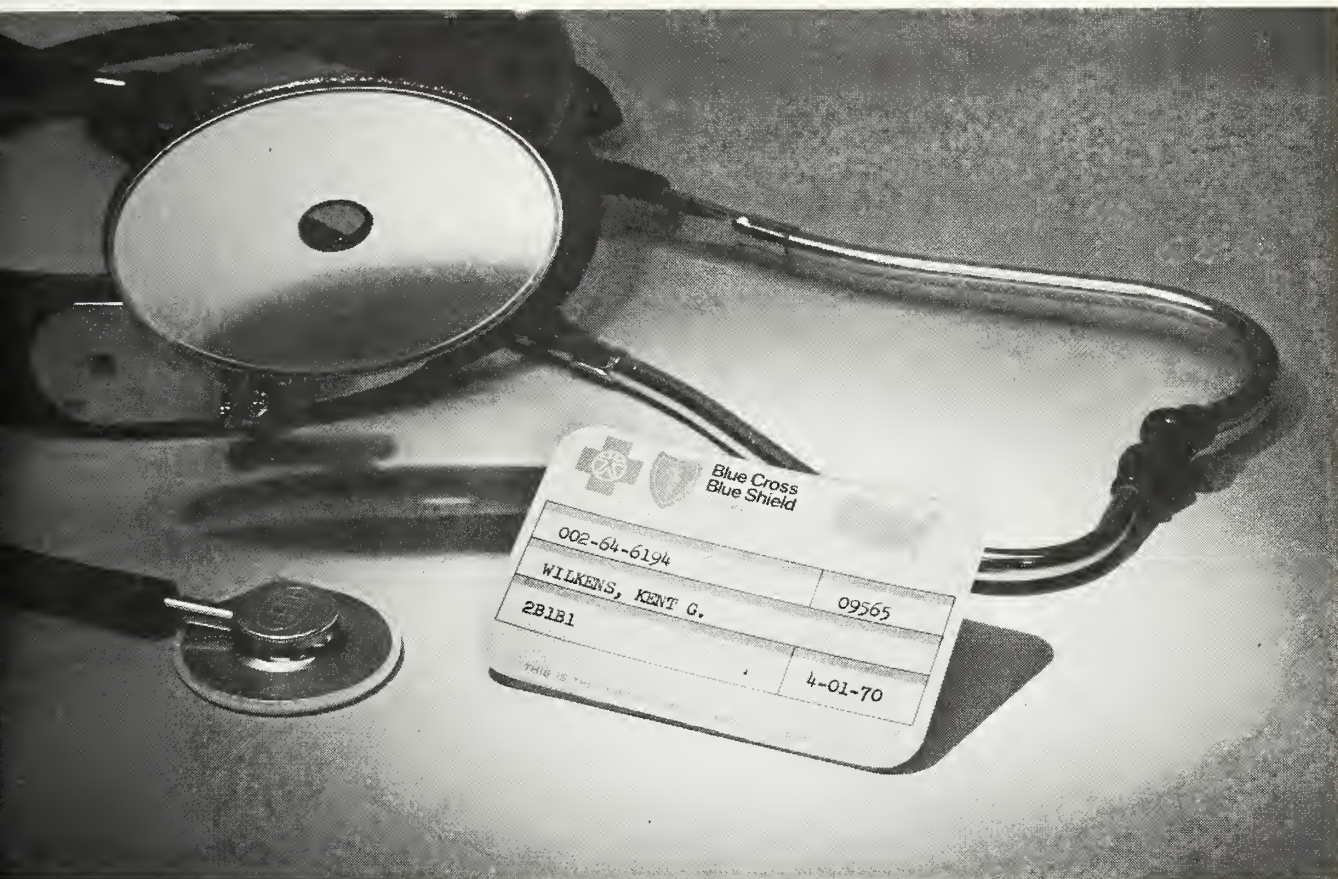
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ABOUT THE COVER

Our cover features a portrait of John Stough Bobbs, M.D. (1809-1870). The Hoosier-born physician was the first to perform a cholecystotomy. For more about Dr. Bobbs, see Medical Museum Notes, Page 201.



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even in compromised patients...

lack of nephrotoxicity makes Monistat i.v. the therapy of choice

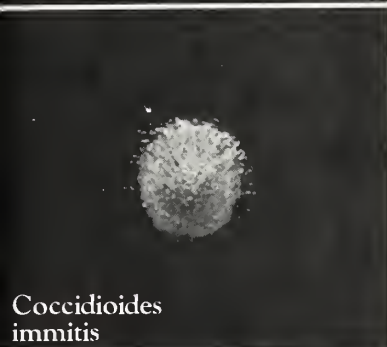
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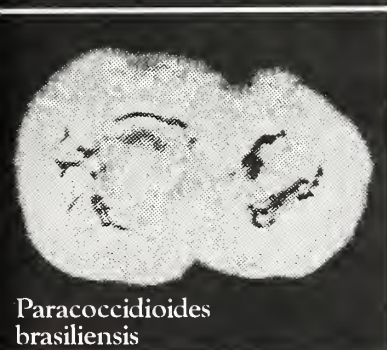
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No renal damage has been reported in long-term use.
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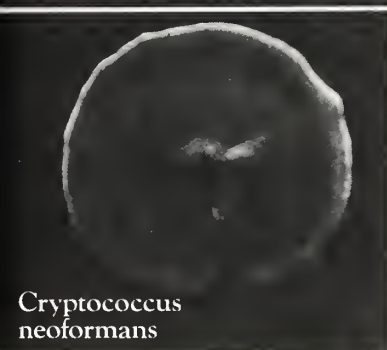
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Highly effective, improvement often seen within 1-3 weeks

Patients who do not respond or develop
resistance to amphotericin B
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Resistance does not develop

In vitro resistance of clinical isolates
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Generally well tolerated by severely debilitated patients

Patients with cancer, those receiving
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with serious underlying conditions,
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Burrows, W., Textbook of Microbiology, W.B. Saunders
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An important advance in
the treatment of systemic mycoses

Monistat i.v.

(miconazole)

TRADEMARK

broad-spectrum antifungal agent



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New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done

Broad-spectrum antifungal agent

Monistat i.v.

TRADEMARK

(miconazole)



for intravenous infusion

DESCRIPTION: MONISTAT i.v. (miconazole), 1-[2-(2,4-dichlorophenyl)-2-[(2,4-dichlorophenyl) methoxyl] ethyl]-1H-imidazole, is a synthetic antifungal supplied as a sterile solution for intravenous infusion. Each ml of this solution contains 10 mg of miconazole with 0.115 ml PEG 40 castor oil, 1.0 mg lactic acid USP, 0.5 mg methylparaben USP, 0.05 mg propylparaben USP in water for injection. Miconazole i.v. is a clear colorless to slightly yellow solution having a pH of 3.7 to 5.7.

CLINICAL PHARMACOLOGY: MONISTAT i.v. is rapidly metabolized in the liver and about 14% to 22% of the administered dose is excreted in the urine, mainly as inactive metabolites. The pharmacokinetic profile fits a three-compartment open model with the following biologic half-life: 0.4, 2.1, and 24.1 hours for each phase respectively. The pharmacokinetic profile of MONISTAT i.v. is unaltered in patients with renal insufficiency, including those patients on hemodialysis. The in-vitro antifungal activity of MONISTAT i.v. is very broad. Clinical efficacy has been demonstrated in patients with the following species of fungi: *Coccidioides immitis*, *Candida albicans*, *Cryptococcus neoformans*, and *Paracoccidioides brasiliensis*.

Recommended doses of MONISTAT i.v. produce serum concentrations of drug which exceed the in-vitro MIC values for the fungal species noted above. Doses above 9 mg/kg of MONISTAT i.v. produce peak blood levels above 1 µg/ml in most cases. The drug penetrates into joints.

INDICATIONS: MONISTAT i.v. is indicated for the treatment of the following severe systemic fungal infections: coccidioidomycosis, candidiasis, cryptococcosis, paracoccidioidomycosis, and for the treatment of chronic mucocutaneous candidiasis. However, in the treatment of fungal meningitis and urinary bladder infections an intravenous infusion alone is inadequate. It must be supplemented with intrathecal administration and bladder irrigation. Appropriate diagnostic procedures should be followed and MIC's should be determined.

MONISTAT i.v. should not be used to treat common trivial forms of fungal diseases.

CONTRAINDICATIONS: MONISTAT i.v. is contraindicated in those patients who have shown hypersensitivity to it.

WARNINGS: Rapid injection of undiluted MONISTAT i.v. may produce transient tachycardia or arrhythmia.

PRECAUTIONS: Before a treatment course of MONISTAT i.v. is started, the physician should make sure that the patient is not hypersensitive to the drug product. MONISTAT i.v. should be given by intravenous infusion. The treatment should be started under stringent conditions of hospitalization but subsequently may be given to suitable patients under ambulatory conditions with close clinical monitoring. It is recommended that an initial dose of 200 mg be given with the physician in attendance. It is also recommended that clinical laboratory monitoring including hemoglobin, hematocrit, electrolytes and lipids be performed.

It should be borne in mind that systemic fungal mycoses may be complications of chronic underlying conditions which in themselves may require appropriate measures.

JANSSEN PHARMACEUTICA INC.

501 George Street
New Brunswick, N.J. 08903

Attn: D.T. Mallegol

Please send me more information about the use of
MONISTAT i.v.TM (miconazole) in systemic candidiasis
and other systemic mycoses.

M.D.

Address _____

City _____ State _____ Zip _____

Specialty _____

April, 1980

Pregnancy: Reproductive studies with MONISTAT i.v. in rats and rabbits revealed no evidence of impaired fertility or harm to the fetus. There are no data, however, on the use of the drug in pregnant women.

Children: Since the safety of miconazole i.v. in children under one year of age has not been extensively studied, its benefits in this age group must be weighed against the possible risks involved.

ADVERSE REACTIONS: Adverse reactions which have been observed with MONISTAT i.v. therapy include phlebitis, pruritus, rash, nausea, vomiting, febrile reactions, drowsiness, diarrhea, anorexia and flushes. In the U.S. studies, 29% of 209 patients studied had phlebitis, 21% pruritus, 18% nausea, 10% fever and chills, 9% rash, and 7% emesis. Transient decreases in hematocrit and serum sodium values have been observed following infusion of MONISTAT i.v. Thrombocytopenia has also been reported. No serious renal or hepatic toxicity has been reported. If pruritus and skin rashes are severe, discontinuation of treatment may be necessary. Nausea and vomiting can be mitigated with antihistaminic or antiemetic drugs given prior to MONISTAT i.v. infusion, or by reducing the dose, slowing the rate of infusion, or avoiding administration at mealtimes.

Aggregation of erythrocytes or rouleau formation on blood smears has been reported. Hyperlipemia has occurred in patients and is reported to be due to the vehicle, Cremophor EL (PEG 40 castor oil).

DRUG INTERACTIONS: Drugs containing cremophor type vehicles are known to cause electrophoretic abnormalities of the lipoprotein. These effects are reversible upon discontinuation of treatment but are usually not an indication that treatment should be discontinued.

Interaction with the coumarin drugs resulting in an enhancement of the anticoagulant effect has also been reported. In cases of simultaneous treatment with MONISTAT i.v. and coumarin drugs, the anticoagulant effect should be carefully titrated since reductions of the anticoagulant doses may be indicated.

DOSAGE AND ADMINISTRATION:

DOSAGE

Adults: The doses may vary with the diagnosis and with the infective agent, from 200 to 1200 mg per infusion. The following daily doses, which may be divided over 3 infusions, are recommended:

Organism	Dosage Range*	Duration of Successful Therapy (weeks)
Coccidioidomycosis:	1800 to 3600 mg per day	3 to >20
Cryptococcosis:	1200 to 2400 mg per day	3 to >12
Candidiasis:	600 to 1800 mg per day	1 to >20
Paracoccidioidomycosis:	200 to 1200 mg per day	2 to >16

*May be divided over 3 infusions.

Repeated courses may be necessitated by relapse or reinfection.

Children: A total daily dose of about 20 to 40 mg/kg is generally adequate. However, a dose of 15 mg/kg body weight per infusion should not be exceeded.

ADMINISTRATION: MONISTAT i.v. should be diluted in at least 200 ml of fluid. The diluent of choice is 0.9% sodium chloride or alternatively Dextrose 5% injectable solution. The intravenous infusion should be given over a period of 30 to 60 minutes.

Generally, treatment should be continued until all clinical and laboratory tests no longer indicate that active fungal infection is present. Inadequate periods of treatment may yield poor response and lead to early recurrence of clinical symptoms. The dosing intervals and sites and the duration of treatment vary from patient to patient and depend on the causative organism.

OTHER MODES OF ADMINISTRATION: *Intrathecal.* Administration of the undiluted injectable solution of MONISTAT i.v. by the various intrathecal routes (20 mg per dose) is indicated as an adjunct to intravenous treatment in fungal meningitis. Succeeding intrathecal injections may be alternated between lumbar, cervical, and cisternal punctures every 3 to 7 days. Bladder instillation of 200 mg of diluted solution is indicated in the treatment of mycoses of the urinary bladder.

HOW SUPPLIED: MONISTAT i.v. is supplied in 20 ml ampoules.

MONISTAT i.v. (miconazole) is an original product of Janssen Pharmaceutica N.V., Belgium.



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CHARLES A. BONSETT, M.D., Indianapolis

The World's First Gall Bladder Surgeon Was a Hoosier

JOHAN STOUGH BOBBS (1809-1870), Indiana's innovative pioneer surgeon, performed the world's first gall bladder surgery June 15, 1867. (See Dr. Robert S. Sparkman's articles in *THE JOURNAL*, pp 541-554, May 1967.)

The Bobbs portrait (which now hangs in the amphitheater of the Medical Museum) is reproduced in color on the cover of this issue, and the photographic reproduction of his life-size bronze in bas-relief appears on this page.

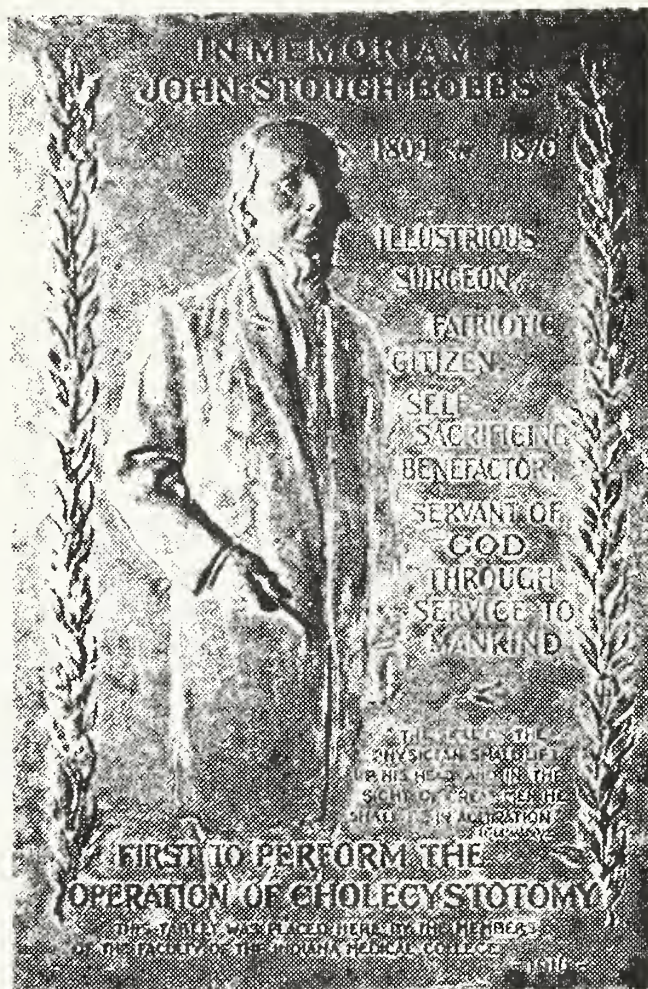
The bas-relief was done by Gutzon Borglum, the son of a physician, who later in his career gained international recognition for his colossal work of carving four presidents from Mount Rushmore in South Dakota.

The bas-relief was sculpted in 1914 and was placed in the St. Clair Street library, which was completed in the same year. This memorial comprised the center of attraction to the wing identified as the Bobbs Medical Library.

Bobbs' own medical library, together with a substantial sum of money, had been willed to the Indiana Medical College in 1870. The library was originally placed in the medical school building at Delaware and Court Streets but was later moved to Pennsylvania and Maryland Streets when the school moved its quarters.

The Bobbs library was highly regarded (in Indiana at least) as the finest medical library west of the Allegheny Mountains. This entire library (except for one book now in the Museum) was destroyed by fire Nov. 3, 1894. The following year the school moved into a new building at Market Street and Senate Avenue, this becoming Indiana University School of Medicine in 1908.

Meanwhile, the destroyed Bobbs library was rebuilt (in terms of books and journals) through the tireless efforts of Dr. Frank B. Wynn. The collection was



placed in the Indianapolis Public Library at Meridian and Ohio Streets, which made it accessible to students of both medical schools in Indianapolis.

In 1914 the Bobbs library was moved to the elegant new St. Claire Street location; the library reached its zenith during the following decade. Its usefulness gradually declined, however, as the medical library at I.U.M.C. developed. During the 1950s it ceased to function.

Some of the Bobbs books (e.g., the Mears collection) are now in the I.U.M.C. library. The bas-relief of Dr. Bobbs remains in its original location. Unfortunately, it is now concealed from public view, and the public now can neither appreciate this example of the art of Gutzon Borglum nor be reminded of Dr. Bobbs' contribution to humanity.

EDITORIALS

ADR Reporting System Works

The adverse drug reaction reporting system is one of the details that comprise the FDA drug safety program. For some reason, even a prolonged clinical research trial of a new preparation will not produce the massive clinical experience that ensues after FDA approval of the new drug for general use.

"Selacryn" is a good example—approved for marketing last May and now suspended by its maker, Smith Kline & French, because of incidence of liver damage of somewhere between 1 in 1,000-5,000 cases. Within one day a letter went to all the nation's physicians, the next day to pharmacists. France, Canada and Germany have been notified. The system works! This is good, not only for patient safety, but also because dependable early reporting of adverse reactions will tend to make the original FDA release of a new drug earlier.

AAFP Confronts Malpractice Resurgence

Medical malpractice suits are again on the increase, and premiums for malpractice insurance are rising.

The American Academy of Family Physicians is offering its members a program designed to acquaint physicians and patients with methods of prevention.

The Professional Liability Information Program (P.L.I.P.) was developed in 1977 and contributed to a stable condition in malpractice. It is again relevant to today's situation.

Components of P.L.I.P. are: 1) A brochure, "Eleven Ways to Minimize the Risks of Professional Liability Suits," 2) A patient education leaflet on malpractice for the reception area, and 3) A slide presentation illustrating the "Eleven Ways . . .," and a speech text outlining the "Eleven Ways . . ." to be used with the slide presentation.

Lightning and CPR

The American College of Emergency Physicians reports on injuries by lightning in a recent issue of ANNALS OF EMERGENCY MEDICINE. More people are killed by lightning than by tornadoes. The article infers that the public should be much better instructed, both in prevention of lightning strikes and in prompt and aggressive treatment at the site in case the victim is unconscious, paralyzed or has cardiopulmonary arrest. All of these probably fatal situations are susceptible to recovery if correctly handled immediately. Medical societies and the Red Cross should cooperate in holding public meetings for a few good words of advice. Everyone, by the way, should be taught to perform cardiopulmonary resuscitation.

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3—Richard G. Huber, Bedford	Oct. 1982
4—Howard C. Jackson, Madison	Oct. 1980
5—Paul Siebenmargen, Terre Haute	Oct. 1981
6—Davis W. Ellis, Rushville	Oct. 1982
7—Donald C. McCallum, Indianapolis	Oct. 1980
7—Jahn G. Pantzer, Indianapolis	Oct. 1981
8—Jack M. Walker, Muncie	Oct. 1981
9—Jahn A. Knate, Lafayette (Chairman)	Oct. 1982
10—Martin J. O'Neill, Valparaiso	Oct. 1980
11—Herbert C. Khalouf, Marian	Oct. 1981
12—DeWayne L. Hull, Fort Wayne	Oct. 1982
13—Donald S. Chamberlain, South Bend	Oct. 1980

ALTERNATES

District	Term Expires
1—E. DeVerre Gaurieux, Evansville	Oct. 1982
2—Edgar R. Cantwell, Vincennes	Oct. 1980
3—	
4—Mark M. Bevers, Seymour	Oct. 1982
5—Benny Ka, Terre Haute	Oct. 1982
6—Dan W. Hibner, Richmond	Oct. 1981
7—Jahn D. MacDaugall, Beech Grove	Oct. 1982
7—H. Marshall Trusler, Indianapolis	Oct. 1982
8—Richard L. Reedy, Yarktown	Oct. 1982
9—Max N. Hoffman, Cavington	Oct. 1980
10—Leonard W. Neal, Munster	Oct. 1982
11—Fred C. Paehler, La Fontaine	Oct. 1980
12—Franklin A. Bryan, Fort Wayne	Oct. 1980
13—Jahn W. Luce, Michigan City	Oct. 1982

P.P.I. Suit Dismissed

A Federal District judge recently dismissed the longstanding suit that sought to prevent FDA from mandating patient package inserts for estrogen products.

The case was filed in 1977 when FDA proposed the regulation. The Pharmaceutical Manufacturers Association, together with the American College of Obstetricians and Gynecologists, National Association of Chain Drug Stores, American Society of Internal Medicine, Private Medical Care Foundation, Congress of County Medical Societies, Pottawatomie County Medical Society, Oklahoma State Medical Association, and Francis A. Davis, M.D., filed suit and sought an injunction.

The judge denied the motion for injunction and in dismissing the suit said that the FDA has statutory authority to require patient labeling, that PPIs do not interfere with any constitutionally protected rights of physicians, that the agency's reasoning is sufficiently articulated and that the record adequately supports its judgment.

PMA states the judge's findings do not refer to all drugs, or all PPIs. "A specific administrative determination that, due to the peculiarities of a particular drug and its customary use, its labeling would be false and misleading without specific additional information."

And the PMA reports that elsewhere the judge says: "The Commissioner states that, unlike the situation with respect to other drugs, he finds no likelihood of a substantial adverse effect on patients from exposure to the information provided by the labeling."

The PMA also reports that the judge says: "As I read the regulation, if a doctor feels the manufacturer's labeling is slanted or unduly alarming, he or she has the additional alternative of preparing substitute labeling so long as that labeling covers the subject matter required by the regulation. As earlier noted, the guideline at 41 Fed. Reg. 43108 and updated 42 Fed. Reg. 37645 is not mandatory. It is simply a sample text which may be relied on as complying with the requirements of the regulation."



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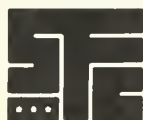
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WHAT'S NEW?

CONTINUED FROM PAGE 195

ABBOTT has a spectrophotometric enzyme immunoassay for detection of Hepatitis B Surface Antigen (HBsAg). Auszyme™ is a nonradioactive assay and has a shelf life longer than Ausria® II-125. Auszyme is a qualitative procedure for either serum or plasma.

THE AMERICAN SOCIETY of Clinical Pathologists has published *Epidemiology of Hospital-Associated Infections*, by Peter C. Fuchs, M.D. Dr. Fuchs is an epidemiologist in the Department of Pathology at St. Vincent Hospital and Medical Center in Portland, Oregon. He discusses the diverse factors involved in establishing and maintaining an effective infection control program. The book is written for epidemiologists, nurse epidemiologists, microbiologists, pathologists, physicians, hospital administrators, infection control committees and surveillance teams. 220 pages, \$25.

GRUNE & STRATTON has released *Induced Disease*, a collected work from physicians of North America and the United Kingdom on the subject of diseases induced by drugs, other chemicals, irradiation and occupation. It is intended for broad physician readership. It stresses diagnosis and management, with special emphasis on diagnostic radiology. The editor is Leslie Preger, M.B., F.R.C.R., Director, Radiological Department, French Hospital, San Francisco. The book also deals with radiation hazards, especially in regard to women of childbearing capacity. 416 pages, 175 illustrations, \$35.

THE BIRD CORPORATION has a new oxygen/air blender, which combines high and low flow capabilities into one unit. Designated the Model 3300, the Bird Hi/Lo Flow Oxygen Blender may be used during routine respiratory therapy procedures requiring low flow oxygen administration, as well as more sophisticated life-support procedures requiring high pressure oxygen/air mixtures.

ANCHOR PRESS has released *The Right Brain*, by Thomas R. Blakeslee. The book outlines a new understanding of the unconscious mind and its creative powers. The basic premise is that both sides of the brain possess capability of thinking and learning but only the left brain can express itself in words. 288 pages, \$10.95.

FOR PEOPLE INTERESTED in exercise, Delta Books announces *Playing the Racquets*, by Carol Morgenstern and *The Wonderful World of Walking*, by Bill Gale. *Racquets* covers all the games played with either a racquet or a paddle. *Walking* is written for people who don't want to or cannot safely jog. The prices are \$7.95 and \$5.95, respectively.

LEXINGTON BOOKS is releasing *Angel Dust*. The book profiles users of phencyclidine (PCP) in several large cities in the U.S. More than 300 users of the drug were interviewed to assess the patterns of use, the social dynamics of PCP-using groups, and the psychological, physical and social effects of extended use. 240 pages, \$14.95.



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MEDICARE SUPPLEMENT PLAN provides "gap filler" benefits so essential today. Medicare revised their benefits effective January 1, 1979 and these ISMA sponsored plans have been revised to update these changes, supplementing both Medicare Part A and Part B.

OTHER INSURANCE PLANS AVAILABLE:

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- **OVERHEAD EXPENSE PLAN** provides needed dollars to help you pay off overhead expenses (employees' salaries, rent, utilities, property taxes, etc.) in the event of your covered disability. When disability strikes—your business overhead expenses keep right on going—even when you can't.
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LETTERS

The Treason Trust

More than 30 years ago, Eric Blair, an English journalist using the pseudonym George Orwell wrote a book—1984—exposing the evil designs of Communism. Blair had experienced a long life of collaboration with Socialists and Communists. It is now apparent that he was not only a journalist and novelist, but also a prophet.

Blair predicted the alignment of evil world forces, forces that now include the United States because we have helped strengthen the U.S.S.R. and are now doing the same for Red China.

We were led into World War I by people who used their financial power to blackmail President Wilson into foreign entanglements. For example, international bankers from Germany and the United States supplied money to Lenin and Trotsky to overthrow the Christian government of Russia in 1917 in a bloody revolution that could have been sustained only by those who subsidized the plot.

In 1933 Roosevelt became the first U.S. President to recognize the U.S.S.R. He made a deal with Litvinof, a convicted bank robber who represented the Soviets, and made promises with those atheistic thugs that were never intended to be kept.

In spite of adequate moral guidance, Roosevelt used federal tax revenues to help the Communists.

Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is encouraged. Letters should be addressed c/o THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

He maneuvered us into World War II by failing to notify our Pearl Harbor command that the Japanese were about to attack them. He and his co-conspirators, General George Marshall and Secretary of State Cordell Hull, knew on Dec. 6, 1941 of the Japanese plans to attack Pearl Harbor. Yet these people allowed our fighting men and equipment to be demolished so that we could join the Communists and British in the war with Hitler.

Similar treachery marks the incumbency of every other U.S. President to date—but not as badly as we find under the present Administration that has engineered the “payaway” of the Panama Canal, the recognition of Red China, the illegal abrogation of our treaty with Taiwan, and the futile attempt to keep Communists in control of Chile. The Carter Administration also provided aid to Communists to oust anti-Communist Somoza’s government in Nicaragua, but twice in 1979 refused aid to the Afghan anti-Communist leader, Zia Khan Nassry.

Top off this record with the fact that the Carter Administration first worked to oust the Shah of Iran and then refused to alert the U.S. Embassy at Teheran of impending danger. Now we witness, via prime time, the mob control of American hostages in Teheran. And what is our government doing? They are appealing to a Communist devised and controlled United Nations to extricate our citizens from Iran; we need such help because we already have built up the Red enemy’s military force to exceed our own.

A disgraceful majority of Congressmen have violated their oath of office by aiding rather than stopping these acts. Several of them are now running for President, and any objection by the electorate is silenced by a controlled news media.

Our Constitution defines treason as giving aid and comfort to our enemies. The above facts fit this description.

William Penn said that those who refuse to be governed by the Laws of God shall be ruled by tyrants. We are near that stage now, but we can reverse the trend by obeying the Laws of God and those of our Christian founding fathers who gave us our Constitution. It can be done no other way.

A. G. BLAZEY, M.D.
Santa Claus, Ind.

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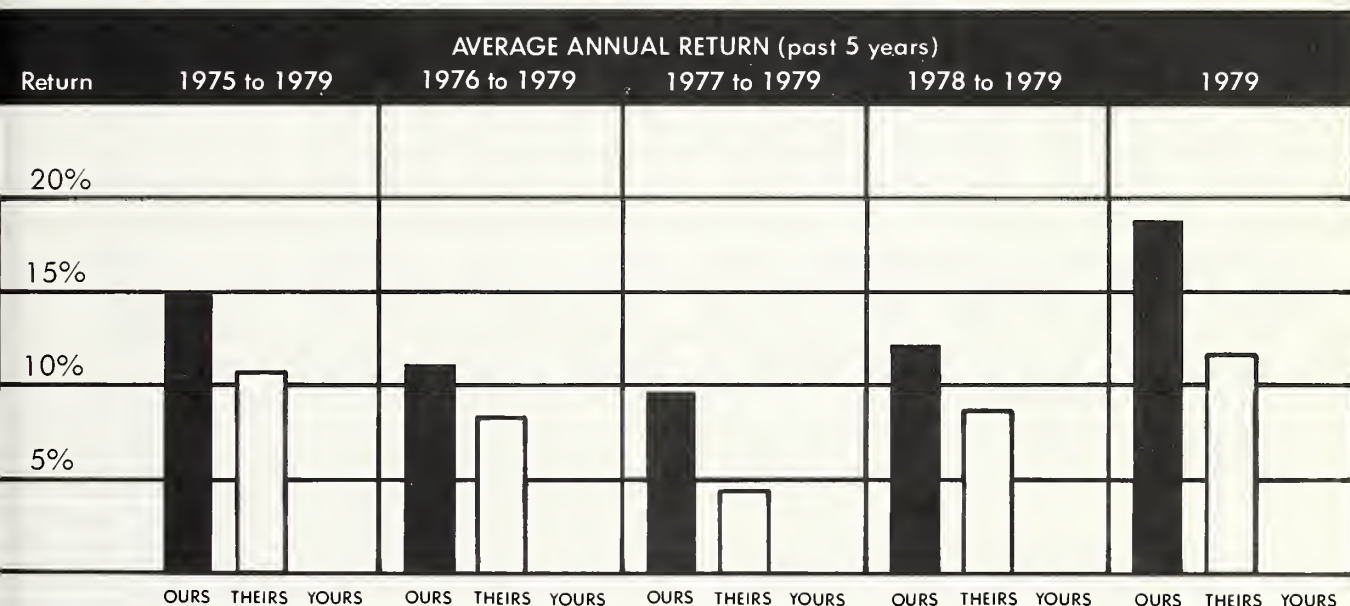
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The Hard Sell

Guest Editorial

STEPHEN D. WARD, M.D.

Wheeling, W. Va.

I DON'T REGARD myself as particularly irritable. And I've never been inclined to brood, at least excessively. Separate bits of irritants, however, have a way of accumulating, perhaps like holes in your socks. One or two in a drawer full is tolerable but when every second sock is so afflicted it does something to you. It can ruin your whole day.

Have you ever noticed the number of public service announcements on TV and radio or the corresponding PR schlock obsequiously or, perhaps, just mindlessly printed in newspapers? The numbers seem to be increasing all the time. They're not all that bad, either.

I've been downright tempted a number of times recently to go down to the Social Security office to check on the possibility of getting a little disability income. The desirability of being found eligible for food stamps has been going up in direct proportion to the size of the supermarket bill even without media encouragement to apply.

Reprinted with permission from THE WEST VIRGINIA MEDICAL JOURNAL, in which this guest editorial appeared in February 1980. The author is president of the West Virginia State Medical Association.

Recent cold weather seems to have brought on a blizzard of invitations to come down and get a little help with my fuel bill.

The Department of Agriculture and Labor Department are always asking me to write for fascinating-sounding information or services. Some of the more sophisticated bureaus following good business practice seem to be developing toll-free numbers.

Then, too, there's the local Mental Health Center. The possibilities presented here seem almost endless. If I drink a little bit too much, fight with the wife, have trouble with the neighbors, happen to get raped, can't make it to work often enough, don't know what to do with the kids or just generally need advice or someone to talk to, they've got just the right program to make me feel all better. If I weren't already in the business and able to recognize the hyperbole, I'd have been down there long ago.

The question that keeps popping up in my mind is why must they merchandise these programs so heavily if there is such a crying need for them that they were found necessary in the first place? I can understand Chrysler's problems. Do these programs have the same trouble as Chrysler? Might we have government buildings full of expectant but yawning helpers without the hard sell?

I have examined a budget or two submitted by agencies, some quite small, within HEW (now the Department of Health and Human Services) and have been surprised at the number of PR positions slotted and funded. I am sure there are very talented people who fill these positions—which observation, in itself, might place them a cut above the general run of government employees. The quality of their work or output per man hour, moreover, must certainly be exceptional.

Nonetheless, I think they all ought to be fired. The Federal Government already has a monopoly on welfare generosity. With whom does it compete? Drummers and hucksters clearly are not needed. They add nothing to whatever benefits any welfare program might offer the bona fide needy. Without them we might be able to assess the real need for the programs, rather than the need of those operating the programs for a secure job.

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Following is the text of the opening address delivered in February by Lowell H. Steen, M.D., during the 1980 AMA National Leadership Conference held in Chicago. Dr. Steen, a Hammond, Ind. internist, is a past president of the Indiana State Medical Association. A member of the AMA Board of Trustees since 1975, he was elected chairman of that board last year, becoming the first Indiana physician ever to hold the position.



Lowell H. Steen, M.D.
Chairman
AMA Board of Trustees

The Power of Good Leadership

Welcome to this conference and welcome to what it can do for each of us—and for our entire profession.

The conference agenda will enable us to take a hard, penetrating and fresh look at what the "Power of Leadership" signifies for us today. As the challenges to our profession and our AMA federation grow and expand, so do the demands placed upon that power of leadership.

Leadership in our federation today has to constitute far more than being elected to office. And power has to constitute far more than exercising the rights and privileges of that office. Truly powerful leadership means active concern with substance rather than mere form. It means influence rather than mere authority—and effectiveness as opposed to mere exertion or exhibition.

Truly powerful leadership requires all of the one-word attributes emblazoned on banners around this hall. Let us consider some of them—starting with **knowledge**. The more we know about health-care issues and their significance for all of us, the more we realize how interdependent

the county, state, specialty, and national levels of our federation have to be in addressing the issues.

Wisdom includes putting that interdependence to work as helpfully and effectively as possible. It includes the best possible expenditure of our time, our energies and our money. Today, no such expenditure is more important than enabling consumers to hold down *their* expenditures for health services.

The Administration's Congressional push for mandatory cost controls on hospitals is down but it's not out. And we've got to do everything we can—in counties, states and nation—to help the voluntary effort keep looking up.

Let's not claim early victory just because the voluntary effort saved consumers \$3 billion from 1977 through last year, and because physicians' fee increases have kept several points below the consumer price index's all-items rate. Rather, let's say that we've just begun to fight.

We've got to demonstrate that we have just as much **enthusiasm** and **decisiveness** fighting for the consumer's welfare and for other causes as we have fighting against unfair legislation and regulation. We've got to demonstrate that we have **compassion** for the anonymous consumer as well as for the familiar personal patient.

Yes, we've been showing compassion in a number of different ways—from stimulating the growth of rural-area care and primary care to publicizing the need for proper immunization and nutrition. But we've got to make our public spirit more emphatic and more evident if we are to earn more goodwill from the public and from the media as the voice of the public. No challenge to medical leadership is more imperative than this.

Courage is one of the most useful mottoes on the hall banners. It takes courage to uphold our professionalism against threats and assaults from *outside* our ranks, such as those made by government. But leadership must also have the courage to safeguard our professionalism against dangers *inside* our ranks. I refer specifically to the dangers posed by errant and incompetent physicians. AMA model legislation for disciplining them has been wholly or partially adopted in 20 states, and has enabled state disciplinary actions to multiply tenfold in seven years. We need to work for even greater responsibility on this problem in states that have the legislation—and for enactment of the model bill in other states. This form of responsibility is a vital link in public goodwill.

Still another banner motto is **vitality**. This involves not only the energy to do things, but the

CONTINUED ON PAGE 217



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Pale green 300 mg. tablets
in bottles of 100 and Single Unit Packages of 100
(intended for institutional use only).

Injection, 300 mg./2 ml.,
in single-dose vials
and in 8 ml. multiple-dose vials,
both in packages of 10.

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Alpha Stimulation

Central Control of
Blood Pressure*



The Family of Man® by Roberto Moretti,
a statuary in crystal symbolizing the broad range of
hypertensive patients eligible for therapy with Catapres.

The Alpha Advantage:

It's for all kinds of hypertensives

- Unlike beta blockers, Catapres® has no contraindications.
- Catapres can be useful even in these patients with:

Congestive heart failure	Allergic rhinitis
Ventricular hypertrophy	Hepatic disease
Hyperglycemia	Hyperuricemia
Diabetes mellitus	Gouty arthritis
Bronchial asthma	Sulfonamide hypersensitivity

Like any antihypertensive, use with caution in severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

work/play—normal hemodynamic responses to exercise maintained.

love—low incidence of impotence and/or loss of libido:
2.8% in 1,923 patients studied.¹

cardiac output—tends to return to control values during long-term therapy.

blood flow—preserved in kidney.

No Single Advantage Determines Drug Choice.

Other factors must include:

The drug's effectiveness in a given patient, its side effects, warnings, precautions, tolerance, etc. A rational therapeutic choice depends on a careful assessment of all such factors.

* Central alpha-adrenergic stimulation decreases sympathetic outflow from the brain, as shown in animal studies.

¹ Data on file at Boehringer Ingelheim Ltd.

Please see last page for brief summary, including warnings, precautions, and adverse reactions.

**Now available in new
0.3 mg tablets**

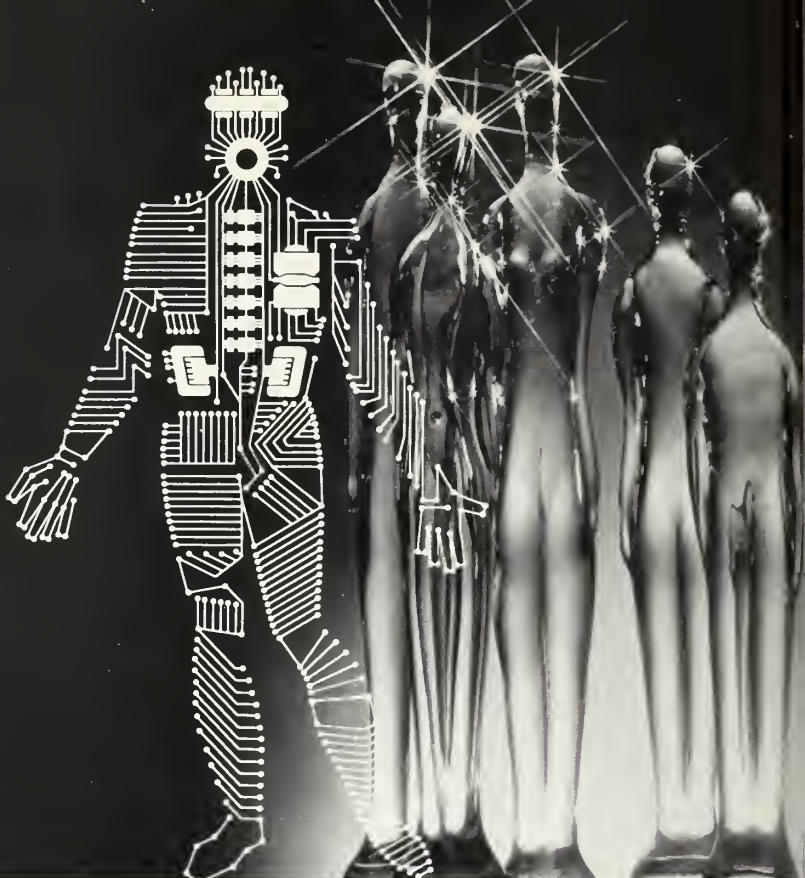
Tablets of 0.1, 0.2, 0.3 mg
Catapres®
(clonidine HCl)
Hypertension



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The Alpha Advantage: It's for all kinds of hypertensives

Tablets of 0.1, 0.2, 0.3 mg
Catapres
(clonidine HCl)
Hypertension



- No contraindications.
- Effective in all degrees of hypertension. It is mild to moderate in potency.
- Low incidence of depression, impotence, orthostatic hypotension—no fatal hepatotoxicity.
- Preserves kidney blood flow.

Most common side effects are dry mouth, drowsiness, and sedation which generally tend to diminish with time.

Catapres[®]
(clonidine hydrochloride)
Tablets of 0.1, 0.2, 0.3 mg

Indication: The drug is indicated in the treatment of hypertension. As an anti-hypertensive drug, Catapres (clonidine hydrochloride) is mild to moderate in potency. It may be employed in a general treatment program with a diuretic and/or other antihypertensive agents as needed for proper patient response.

Warnings: Tolerance may develop in some patients necessitating a reevaluation of therapy.

Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phentolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months or longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness, sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormal liver function tests; one report of possible drug-induced hepatitis without jaundice and hyperbilirubinemia in a patient receiving clonidine hydrochloride, thalidomide and papaverine hydrochloride. Weight gain, transient elevation of glucose, or serum creatine phosphokinase: congestive heart failure, Raynaud phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes: nervousness, restlessness, anxiety and mental depression. Also rare: gioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness of the eyes, dryness of the nasal mucosa, pallor, gynecomastia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. (Gastric lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

For complete details, please see full prescribing information.

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Professional Education Materials

New professional films and a number of publications are now available from the Distribution Manager, Indiana Division, American Cancer Society. Films and videotapes are available for free short-term loan only (please allow four to six weeks). Publications are furnished free of charge to health care professionals.

FILMS

Blood Components in Cancer Therapy, Code #3792 (16mm film or videocassette). Demonstrates the advantages of selected components over whole blood, identifies the growing range of components available to community hospitals and discusses indications for their use. Two case histories illustrate the benefits of specific components and combinations for leukemic patients—one in a children's hospital and another whose treatment alternates between a cancer center and the local community to fit changing needs.

Detection and Diagnosis of Cervical Cancer, Code #3756 (16mm film or videocassette). Demonstrates the routine pelvic examination, including "Pap" test, and illustrates the probable progress of lesions from cervical intraepithelial neoplasia through microinvasive cancer to frankly invasive cancer. Charts the course of diagnostic steps, explaining indications for Schiller's test, colposcopy, biopsy, conization, and endocervical curettage, each of which is shown in an appropriate patient. Emphasis is on the advantages of detecting cancer of the uterine cervix early, while chances of cure are high.

AUDIO-TAPE

Meeting Highlights: American Cancer Society Conference on Urologic Cancer—1979. Code #3719. Audio-tape available for loan only. Consists of two 60-minute cassettes packaged in a convenient book-type album with a table of contents for locating individual topic and speakers. Contains highlights of the three-day conference. Topics include Surgical Staging, Complications of Survival, Perspective in Radiation Therapy, and Operative Therapy and Hormonal Therapy.

PUBLICATIONS

Proceedings of the American Cancer Society National Conference on the Care of the Child with Cancer, Code #3013. Topics include etiology and evaluation of childhood cancer, advances in supportive care and the management of the impact of the child with cancer—on the patient, family, medical staff, and society. Information is presented on the therapy of several childhood malignancies, including leukemia and non-Hodgkin's lymphoma, as well as on future developments in the management of this disease. Publication, a valuable resource to practicing physicians, nurses, family counselors, and other health allied health personnel, is relatively expensive so it should be distributed primarily to professionals with a special interest in childhood cancer.

Proceedings of the American Cancer Society and National Cancer Institute, National Conference on Nutrition and Cancer, Code #3025. Valuable resource to practicing physicians, nurses, dietitians, nutritionists and other allied health personnel. Topics include nutritional management of the cancer patient, facts about food, vitamins, minerals, fads and future develop-

ments in diet. Information is presented on the nutritional factors and the possible cause and prevention of cancer and the nutritional management of adults and children with cancer. Both intravenous and oral techniques of hyperalimentation for cancer patients also are covered.

Cancer Statistics, Code #3033. Contains a broad spectrum of information, including estimates of cancer incidence for 1979, based upon data from the National Cancer Institute SEER Program, 1973-1976. Data on incidence, development, mortality and survival are detailed, as are cancer incidence and mortality rates around the world. Statistical data are presented in tables and charts; accompanying text discusses the classification of data and research.

Early Diagnosis of Oral Cancer: The Erythroplastic Lesion in High Risk Sites, Code #3411. Despite the easy accessibility of the oral cavity for frequent examination by physicians and dentists, 60% of oral cancers are well advanced by the time they are detected. This pamphlet examines some of the misconceptions contributing to this screening problem and discusses leukoplakia and erythroplasia and their significance in the diagnosis of cancer.

Strategic Withdrawal from Cigarette Smoking. Code #3412. Practical guide to medical professionals and the general public on strategic withdrawal from cigarette smoking. Two experts, in clear non-technical terms, discuss the pharmacological satisfactions of nicotine, psychic and social effects of smoking, obstacles to quitting and alternatives to smoking, including aerobic exercise and other forms of physical awareness.

FUTURE FILE

Hyperbaric Oxygen Conference

The 5th annual conference on Clinical Application of Hyperbaric Oxygen is scheduled for June 11-13 at the Memorial Hospital Medical Center of Long Beach, University of California, Irvine Center for Health Education.

The clinically oriented conference will address the currently accepted uses of hyperbaric oxygen in plenary sessions and will include original papers, workshops, sound slides and scientific exhibits.

For information, contact G. B. Hart, M.D., Director, Baromedical Dept., Memorial Hospital Medical Center, 2801 Atlantic Ave., Long Beach, Calif. 90801.

Child Care Conference

The 15th Annual Indiana Multidisciplinary Child Care Conference will be held May 21-22 at the Marriott Inn, Indianapolis.

Pediatric infectious disease, behavioral pediatrics, pediatric dermatology, adolescent medicine, developmental function, and pediatric neurology will each be presented in seminar form.

For information, write Morris Green, M.D., 1100 W. Michigan St., Indianapolis 46223.

There's a Word for It

SCOLIOSIS

RICHARD J. NOVEROSKE, M.D.
Evansville

A curve of the spine to either side, as seen from behind or in front, without or with the x-ray, is properly called a *scoliosis*.

But there are some people who use the term *rotoscoliosis* when the curve is particularly prominent. I don't know why. Maybe they are impressed by the rotation of the vertebrae in the curved part, when the scoliosis is severe. But rotation is always present in scoliosis, even in mild forms. It's an axiom that the spine can't bend laterally without rotation. Try playing with a dried spine sometime, and you'll see.

So it's redundantly stupid to speak of a *rotoscoliosis*. All scoliosis, mild or severe, has rotation, and it only muddies the thinking for us to speak of a *rotoscoliosis*. Let's simply say *scoliosis*.

Conference for Sex Educators

The Indiana University Institute for Sex Research announces its 1980 Conference for Sex Educators. The program will be held at the Poplars Research Center in Bloomington, July 25 to Aug. 1. This conference will concentrate on updating knowledge in various areas of sexuality curriculum, developing teaching strategies and sharing ideas with other professionals from throughout the country.

In addition to Dr. Paul Gebhard and the staff of the Institute for Sex Research, the faculty will include Dr. George Szasz, Professor of Psychiatry at the University of British Columbia; Dr. Mario Petrini, Director of Educational Programs at Wayne State University Medical School; Dr. Paul Pearsall, Chief of The Problems of Daily Living Clinic, Sinai Hospital, Detroit; Sandra Nohre, University of Minnesota School of Medicine; and Dr. Michael Aronoff, Vice-President, American Venereal Disease Association.

The program includes sessions on: Sexual Attitude Reassessment, Anthropological and Sociological Dimensions; Male and Female Sexuality; Sexuality and the Physical and Mental Impairments; Genitourinary and Reproductive Health; Sexually Transmitted Diseases; and Sexual Dysfunctions.

As an organization accredited for continuing medical education, the Indiana University School of Medicine designates this continuing medical activity as meeting the criteria for 60 credit hours in Category 1 of the AMA Physicians Recognition Award.

For enrollment information write before May 31, 1980 to Michael S. Aronoff, M.D., 600 N. Jordan Avenue, Bloomington, Ind. 47405.

I.U. CME Activities

The following Continuing Medical Education activities are offered by the Indiana University School of Medicine:

April 10—Sports Medicine;

April 11—Coronary Artery Disease: Non-Invasive Evaluation;

April 24—Affective Disorders—Richter Child Psychiatry Conference;

April 30-May 1—Arrhythmias 1980: Hope for the Future;

May 1—The Abnormally Fat and the Abnormally Lean;

May 7-9—Chest Radiology: Something Old, Something New;

June 3-5—Family Practice Review: Part II

For further information, contact Joni Downs, Registrar, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223. Tel: (317) 264-8354.

Depression Today: A CME Learning Package

"Depression Today" is a new three-part CME "multi-media learning package" now available on free loan to medical professionals.

Participants—there is no charge for any part of this program—are eligible to receive a total of 12 CME credit hours in Category 1 for the AMA's Physician Recognition Award.

The program—each part consists of a 34-minute 16mm color film and a monograph—was produced and developed by C.M.E. Communications, Inc., under an educational grant from Merrell-National Laboratories, Inc. It was co-sponsored by the Department of Psychiatry, The University of Chicago/The Pritzker School of Medicine and C.M.E. Communications, Inc.

Part 1 is entitled "Recognizing and Diagnosing Depression;" Part 2, "Managing the Acute Episode and Follow-up Phase;" Part 3, "Special Cases in the Pharmacologic Management of Depression." Portions of the learning package are designed for use in group learning sessions while others are for self-study and reference purposes.

Contact C.M.E. Communications, Inc., 575 Madison Ave., New York, N.Y. 10022.

Duke Postgrad Course

A six-day postgraduate course will be presented by the faculty of the Department of Radiology, Duke University Medical Center July 28-Aug. 2 at Atlantic Beach, N.C.

Scientific sessions will cover pediatric and adult diagnostic radiology, including nuclear medicine, CT and ultrasound. The course is approved for 30 Category 1 credit hours toward the AMA's Physician Recognition Award. The registration fee is \$250, or \$125 for those in training if accompanied by a letter from the appropriate department chairman.

For details, contact Robert McLelland, M.D., Program Director, Radiology-Box 3808, Duke University Medical Center, Durham, N.C. 27710. Tel: (919) 684-4397 or 2711.

Gynecologic Cancer

Gynecologic cancer will be the subject of a national conference to be conducted by the American Cancer Society at the Los Angeles Hilton, Oct. 9-11. No registration fee is required, but advance registration is requested.

The session is approved for 16 hours of AMA Category 1 credit and for 16 AAFP prescribed hours.

Write to Nicholas G. Bottiglieri, M.D., 777 Third Ave., New York City 10017.

CONTINUED ON PAGE 266

Leadership . . .

CONTINUED FROM PAGE 210

stamina to see them through. Litigation is one of the areas in which the national AMA has been showing plenty of stamina.

The AMA has kept rising to the occasion since 1975 in the Federal Trade Commission's case on solicitation of patients and, since 1976, in the chiropractic case, which hasn't even gone to trial yet.

The AMA's various outside legal fees total more per month now than they did per year five years ago. Most other expenses have necessarily risen, too—everything from protecting professional standards to helping the states on legislation and regulation.

All told, the AMA has budgeted \$62 million for 1980 in order to do all it *needs* to do—and is *counted* on to do—in behalf of medical professionalism, organized medicine, and the public.

What the AMA does is collectively determined by the state, county and specialty societies, and is in their interest. As I've said, we're all interdependent. Now, interdependence comprises not only mutual dependence, but also mutual dependability. We have to be able to count on each other for maximum help in membership growth at every level of our federation.

The AMA does everything it can to justify its appeal to non-members as well as members. But the justification has to be made plain in every state and every county. Leaders can act effectively only from a position of strength. That position requires proper funding and, accordingly, an increase in membership.

In representing our profession before government, the media, the public, and the eyes of the future, we have to conduct ourselves in accordance with what is perhaps the greatest of the mottoes on those banners.

That motto is **integrity**. "Integrity" means uprightness. But it is also defined as "the state of being whole, entire or undiminished." In the case of our federation, the two meanings have to come together if we are to be truly strong. We can be *persuasively* upright only if we are intact—intact in our principles and purposes, our determination and drive.

Let us be leaders who, in giving the best of ourselves, do the best for all of our federation.

In the days of this conference, and in all the years to come, let the power of *each* of us be power *with a purpose* for *all* of us.



Vacation Chatter

LAKE MICHIGAN:

Where the Fishing's Fine

With warmer weather approaching, many Hoosier physicians and their families are working up vacation plans. In its belief that Indiana should be included on that travel/vacation itinerary, THE JOURNAL is pleased to introduce "Vacation Chatter," a feature we hope will prompt readers to submit personal accounts of the state's leisure assets. So if you'd like to share your Indiana vacation experience, send us a short account, together with a few photographs, for consideration.

EVERY IMAGINATIVE FISHERMAN dreams of a beautiful blue-green lake teeming with game fish. That dream could come true if you're an Indiana physician thinking of a vacation spot. You don't have to travel far to find the miles of Lake Michigan shoreline located in Indiana's two northwestern counties, Lake and Porter.

The Indiana Dunes National Shoreline preserves the fine white sandy beaches and magnificent dunes along Indiana's Lake Michigan shoreline. It's a great vacation area, and Lake Michigan boasts numerous species of fish, including the famous, fighting coho salmon.

Before launching on your dream vacation, be sure you're aware of the equipment you'll need if fishing's on your mind. Start by getting your Indiana resident fishing license, which now costs \$6. And you'll need a trout-salmon stamp on it if that's what you're going after. That's another \$5.

In northwestern Indiana, the most popular fish are the coho and chinook salmon; brown, rainbow and lake trout; and lake perch.

JOHN J. GALLINATTI, M.D.
Crown Point



The author shows off a nice catch . . .

For the novice who hasn't ever fished for any of these species, here are a few tips:

Coho salmon are silver-sided scrappers that can best be caught between late spring and early fall. Their spawning runs during the spring are famous for producing lunker sizes. Use a heavy, freshwater tackle and artificial lures, whether casting or trolling. The same holds true for chinook salmon, which are dark grey and spotted; they spawn in the fall, at which time they develop crooked snouts and an even darker color.

Brown, rainbow and lake trout—all formidable foes when hooked—range from silver-grey to pink to speckled brown. Weights average about five pounds. Again, heavy, freshwater tackle and artificial lures are recommended.

Lake perch are greenish-yellow and are best landed with light tackle. Live baits—minnows, worms or crawdad tails—are best.

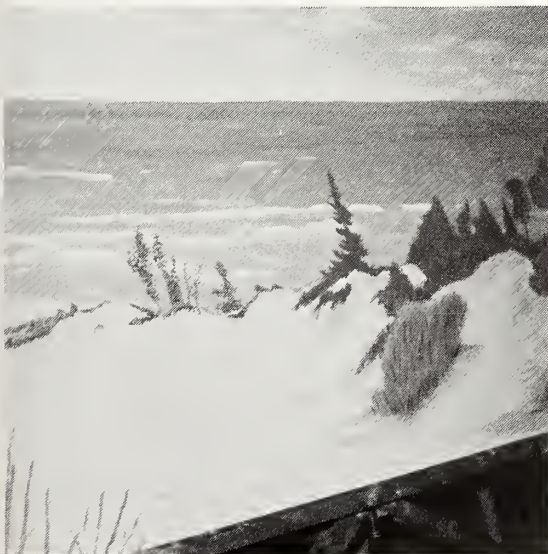
Chartered fishing boats are available from early spring to late fall. If you prefer not to make another move without benefit of more official information, write to the Indiana Department of Natural Resources, Division of Fish and Wildlife, State Office Building, Indianapolis 46204.

Besides trying to land these gourmet delights—or the big one that *didn't* get away—you'll be interested in accommodations along the shoreline. Many low-cost motels and hotels are available.

As far as other activities—camping, hiking, bird watching, swimming, etc.—check with the experts at Indiana Dunes State Park or the Indiana portion of the National Lakeshore Park. Guided tours can enhance your knowledge of the fish, flora and fauna of the fascinating, nearly 2,200-acre Indiana Dunes.

The major recreation area there is West Beach, with a bath house and swimming facilities. About 15 miles of hiking trails encompass Cowles and Pinhook Bogs and the park's largest dune, Mt. Baldy.

A day of fishing—or hiking or whatever—on Lake Michigan may be just what the doctor ordered. Why not give it a try?



Lake Michigan and the dunes . . .

Prospecting For Scientific Gold

Editorial

(Although the following editorial appeared in the January 1951 issue of THE JOURNAL, the editors feel its value has not been affected by time. Its purpose is to emphasize the value of written contributions from practicing physicians; perhaps 29 years after it was originally published, this discussion will encourage Hoosier physicians to share their medical findings with their colleagues. And that's one of the purposes of this journal.)

IT IS of great interest to find, at times, practicing physicians, presumably not part of an institutional research staff, who have enough scientific curiosity to think about their cases, to be led thus into a bit of clinical research, and finally to publish their findings. While such a "researcher" may not be able to *prove* anything, his suggestions, or inferences, taken together with those of similar workers elsewhere may be synthesized to produce definite results.

In the February 1950 number of ANNALS OF WESTERN MEDICINE AND SURGERY, a letter to the editor from L. L. Craven, M.D., of Glendale, California, comments on the anticoagulant effect of acetylsalicylic acid and suggests study of its use as a prophylactic agent in preventing thrombosis. He is especially interested in coronary thrombosis and states that

During the past two years, I have advised all of my male patients between the ages of 40 and 65 to take from 10 to 30 grains of acetylsalicylic acid daily as a possible preventive of coronary thrombosis. More than 400 have done so, and of these, none has suffered a coronary thrombosis. From past experience, I should have expected at least a few thrombotic episodes among this group.

In MINNESOTA MEDICINE for October, 1950 we find R. L. Parsons, M.D., of Monterey, Minnesota, and J. J. Heimark, M.D., of Fairmont, Minnesota, collaborating on "The Prediction and Prevention of Coronary Thrombosis in the Younger Age Groups, A Suggestion for Further Study." They are particularly concerned with cases in the fourth, fifth and sixth decades, and aver:

The factors causing a coronary complex in the people in these earlier decades differ markedly from those in the aged. In older people, the primary cause of this trouble is an extensive intimal damage in the coronary arterial tree. Secondary factors are sedentary life, improper diet, and probably disease. In the younger years this initial damage is usually only moderate to minor. Several other factors apparently combine in varying importance to cause an infarction. Among these are prolonged nervous tension, the prothrombin time level, diet, and smoking. It is generally conceded that coronary constriction from chronic over-stimulation due to high nervous tension, worry, and overwork plays an important role in the foregoing disease entity. Therefore, we shall not add further comment. However, it is different with the other factors mentioned.

In the patients with coronary heart disease whom we have observed, we have been impressed by the low prothrombin time uniformly present. Likewise, we have been impressed by the fairly prompt relief of pain in the nonfatal cases when the prothrombin time has been quickly elevated by the use of the anticoagulants, heparin and dicumarol. We also noted that the pain did not often recur if the prothrombin time level was sustained at a sufficient height. Pain, however, was most likely to recur following a meal. Knowing of no explanation for this, we ran a short series of prothrombin time levels (Smith bedside whole blood method) on normal individuals immediately before eating and again an hour afterwards. The results are shown in Table I.

TABLE I. PROTHROMBIN TIME BEFORE AND AFTER MIXED MEAL

Name	Approx. Age	Before Meal (Seconds)	After Meal (1 Hour) (Seconds)
G.P.	24	60*	55
A.G.	55	75†	60
S.L.	22	90†	75
B.J.	19	70*	65
A.R.	24	70†	60

*Light meal

†Moderate to heavy meal

This further observation was made. If the patient was allowed to smoke cigarettes, he frequently was threatened with a syndromal attack. On suspicion, these few tests were run on normal people (Table III).

TABLE III. PROTHROMBIN TIME BEFORE AND AFTER SMOKING

Name	Approx. Age	Fasting 7 a.m. No Liquids (Seconds)	Fasting ½ Hour After smoking 2 Cigarettes (Seconds)
B.J.	19	60	45
C.T.	40	70	60
J.C.	40	45	35
G.A.	45	65	50
A.R.	24	60	45

From this meager evidence, it may be that cigarette-smoking acts not only to constrict the arterial lumen but, what may be more dangerous, to lower the prothrombin time level.

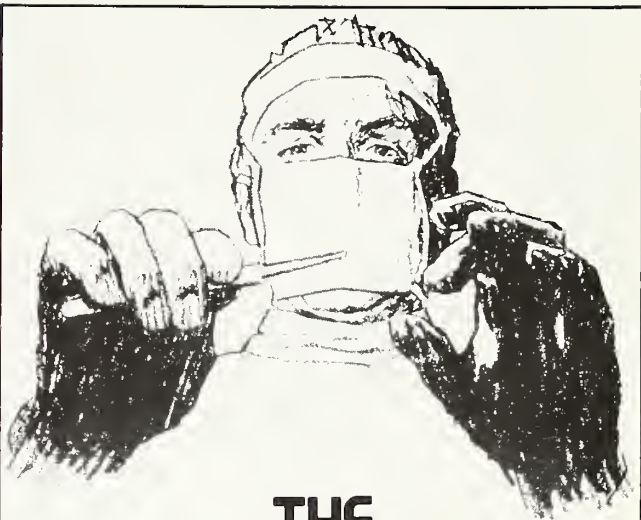
It is known, of course, that a high percentage of people subjected to these same conditions, tension, dietary indiscretions, and smoking, survive into an older age group. There must, then, be some common factor that determine the precipitation of coronary attacks at different ages. We believe this factor to be the difference in prothrombin time level. We believe that this difference in level is a hereditary factor, and that it plays an important role in coronary attacks. Therefore, we believe that coronary attacks are predictable and preventable.

Assuming, then, that this reasoning is correct, should it not be reasonable to assume that by routine testing, individuals prone to coronary disease could be detected and prophylactically treated with dicumarol to elevate the prothrombin time to a satisfactory and safe level just as the diabetic individual can be detected and treated?

We realize, of course, that a prolonged research would be required to establish the proof of this reasoning. Even a few hundred selected people tested and followed through the years should establish the veracity of this contention. We believe, however, that such research in prothrombin time levels would be justified in an attempt to prevent the colossal cost in heart deaths exacted by our modern high-gearred society.

It is true that these reports are based on clinical research on a small scale,—freely admitted by the authors. Yet these men have been thinking about their cases of coronary thrombosis and have done constructive work along the line of prophylaxis. Whether their methods and conclusions will stand up under further research is not so important as the fact that they have at least done more than mental wringing of the hands over a bad situation.

Without doubt there are many practitioners in Indiana who have done considerable thinking about their cases, of whatever sort, but who have remained inarticulate. Letters to the editor are one medium of expression, case reports another, both lending themselves to reporting individual ideas and experiences without elaborate work-up and bibliographic window-dressing. Grains of pollen are mighty small, but may fertilize one of Nature's larger projects many miles away. Besides, your letter-to-the-editor might easily be the saltiest reading matter in that issue. Don't deny your brother practitioners such pleasure,—and such stimulation—as they may obtain. You may have panned a nugget.



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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand, or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°–86° F (15°–30° C). Full information is available on request.

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To obtain Category 1 credit for this month's article, complete the quiz on Page 253.



Outpatient Treatment of Asthma in Children

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ASTHMA IS A LUNG disease characterized by hyperreactivity of the airways to various stimuli. Although these inciting agents may be infectious, thermal, allergenic, exertional, mechanical or emotional in nature, all cause a similar reaction in the hyperreactive lung. Thus, the cause of the reaction leading to a wheezing episode is of secondary importance when confronted with a wheezing child. Our primary concerns are the pathophysiologic mechanisms at work causing the clinical illness.

Three fundamental processes occur in asthmatic children: bronchospasm, hypersecretion of mucus, and airway edema. These in turn cause air trapping, atelectasis, alteration of lung mechanics and

hypoxemia, and are directly responsible for the physiologic consequences of asthma. The physical findings associated with the acute attack are also attributable to these three basic pathophysiologic processes. It is by considering each of these mechanisms that the physician is able to generate a systematic approach to the treatment of the asthmatic child.

BRONCHOSPASM

Bronchospasm is a reaction of the large airways to an inciting agent. The bronchial smooth muscle contracts, narrows the lumen of the bronchus and increases the resistance to air flow. It is this increase in resistance, along with sufficient flow, that generates the expiratory

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wheeze that has become the hallmark sign of asthma. Disappearance of the wheeze can occur with relief of obstruction or with further reduction of expiratory flow. Thus, the patient whose wheeze has diminished in intensity may be becoming more obstructed rather than improving.

In treating the wheezing child much of our therapy is directed at the relief and prevention of bronchospasm. However, in children we must take special care to treat the obstruction of the airways that results from mucus hypersecretion.

MUCUS HYPERSECRETION

Asthmatics have excessive mucus secretion in both large and small airways. This can contribute to airway narrowing during and between attacks. In some patients, mucus hypersecretion leads to plugging of segmental or lobar bronchi, and causes atelectasis.

A common physical finding, associated with mucus production, is the presence of fine and coarse crackles on auscultation. The intensity of breath sounds in different segments may vary markedly, as some airways are more obstructed with secretions than others. Occasionally, children expectorate mucus plugs that have been obstructing large bronchi. It is this mucus that causes the small patchy infiltrates commonly seen on chest roentgenograms of asthmatic children. If we fail to consider treatment of these tenacious secretions in our plan, successful treatment is unlikely.

AIRWAY EDEMA

Edema, like mucus hypersecretion, is present in small and large airways. Airway edema can be considered a relatively fixed obstruction and contributes to the prolonged expiratory phase and the wheeze.

We know that pleural pressure

becomes progressively more negative with increasing obstruction. This favors the movement of fluid out of the pulmonary capillaries and into the lung tissues. The edema fluid produced increases the airway obstruction, resulting in even greater negative pressures.

This new knowledge of fluid dynamics should be considered when making decisions about fluid therapy.

AIR TRAPPING

Air trapping is a result of small airway obstruction by mucus and edema and represents closure of small airways at high lung volume. Trapped air increases residual volume and functional residual capacity. Bronchospasm alone does not cause air trapping. These changes are most vividly demonstrated on the chest radiograph; the diaphragms are depressed or actually inverted, and the retrosternal air space is increased. Air trapping is assumed to be present when, on physical examination, the patient has an increased antero-posterior diameter or is hyperresonant to percussion.

Over one-third of asthmatic children have air trapping *even when they are asymptomatic*.

ATELECTASIS

While air trapping results from partial occlusion, atelectasis occurs when airways, narrowed by bronchospasm, are completely occluded by mucus and edema. The larger the obstructed airway, the larger the atelectasis. Even entire lobes may collapse as a result of mucus plugging. Physical signs of atelectasis include dullness to percussion and diminished breath sounds over the affected area. Palpation of the trachea at the suprasternal notch may reveal tracheal deviation toward the affected side if one of the upper lobes is atelectatic.

LUNG MECHANICS

The diaphragm is at a mechanical disadvantage when trapped air does not allow it to return to its normal position at the end of expiration.

The lungs are stiff because of their high residual volume. These factors result in the patient using his accessory muscles of inspiration to maintain adequate ventilation.

Large swings in intrathoracic pressure can have a deleterious effect on cardiac output. The normally small decrease of systolic arterial pressure during inspiration (usually less than 5 mmHg in normal children) can be greatly exaggerated in patients with severe asthma. This effect on blood pressure is termed *pulsus paradoxus*, and its magnitude has been shown to correlate with the degree of airway obstruction. *Pulsus paradoxus* of greater than 20 mmHg is associated with moderate to severe obstruction.

HYPOXEMIA

Even when well, 25% of asthmatic children are hypoxic. Blood flow to areas of poor ventilation results in a mismatching of ventilation to perfusion and poor oxygenation.

These abnormalities in pulmonary mechanics and oxygenation are present between attacks and must be considered in our treatment plan.

TREATMENT

The treatment of bronchospasm is the first step of our plan.

Relaxation of bronchial smooth muscle can be accomplished by increasing the production of cyclic AMP or decreasing its breakdown. Theophylline and other methylxanthines slow the breakdown of cAMP while the beta agonists (isoproterenol and related drugs) increase its production. Because of the different sites of action, these two drug classes can be used to-

gether and will have an additive effect.

In using theophylline we wish to maintain a steady blood level within the therapeutic range of 10 to 20 mcg/ml. Children generally metabolize theophylline more rapidly than adults but there is considerable variation from child to child. The rate of metabolism is also affected by state of health, diet and concurrent medications or diseases. Thus, dosage requirements vary even within a given patient, and theophylline blood level determinations are needed to properly monitor therapy.

In choosing a theophylline preparation we want one that will maintain blood levels with little variation and so use a time release or sustained release medication when possible. Alcohol does not improve theophylline absorption so those preparations containing significant amounts of alcohol are avoided. Combination medications offer no advantage over pure theophylline properly used, even in mildly affected children.

The beta agonists may be used either by inhalation, injection or by oral dosing. The object of treatment is to obtain the most bronchodilator (beta-2) effect with the least beta-1 effect (cardiovascular effect). Specific choices will be mentioned later.

Secretions: Most children require treatment of mucous obstruction by chest physical therapy. This is especially important in the preschool child who has very small airways that are easily obstructed by secretions. A strict anatomically sound plan for percussion and postural drainage must be followed for good results. We use the positions published by the Cystic Fibrosis Foundation, which are of proven effectiveness. Aerosolized mucolytics may induce bronchospasm and are not recommended.

Edema: Edema is treated with systemic corticosteroids, but preventive drugs such as cromolyn sodium and beclomethasone are used as needed. The use of a short course of prednisone in children who break through their basic therapy is very helpful but should not substitute for a sound management plan.

Using these principles and medication guidelines we can construct a staged plan of therapy for each child.

STAGE I THERAPY

We begin with a theophylline preparation using a dose of 16 mg/kg/day or 400 mg/kg/day, whichever is less.

If possible, the daily dose is given as a sustained release preparation every eight hours; if not, a liquid form is prescribed every six hours. All doses are calculated in milligrams of theophylline. If another salt is used, a conversion is made. For example, liquid aminophylline (Somophyllin®) is 85% theophylline. Thus, each 5 cc is calculated as 90 mg of theophylline, not 105 mg of aminophylline.

Control of mucus is begun in this stage using percussion and postural drainage and an inhaled beta adrenergic agent. We usually use isoe-tharine (Bronkosol®) because it is better tolerated than isoproterenol, and can be measured out in a dose appropriate for each child. Typically, a treatment will take 25 to 30 minutes and is done morning and night. Sputum is usually not expectorated but is swallowed, especially by younger children.

STAGE II

Many patients do well on the regimen outlined in Stage I. However, when patients do not respond to standard treatment, we optimize theophylline therapy by measuring theophylline serum levels and

adjusting the dose. The objective is to maintain a stable level between 10 and 20 mcg/ml. Once this is achieved, a second drug, a beta-adrenergic receptor agonist, is added.

Terbutaline is the best drug to add because it is the most specific beta-2 agent available in the United States. However, this drug is not approved for use in children under 12 years of age, so we use metaprot-erenol (Alupent®, Metaprel®) in our younger patients. By using both theophylline and a beta-2 drug, we are attempting to raise the level of cAMP by two means, thus achieving maximum bronchodilation.

STAGE III

In this stage we assume that all other medications are being used in the highest tolerated doses and that compliance is reasonably good. Under these conditions, we begin to use drugs that act to stabilize cell membranes and prevent the release of the chemical mediators of asthma.

Cromolyn sodium (Intal®) is effective in children as a prophylactic drug. It is not a bronchodilator and must be stopped during a wheezing episode. Its administration using the Spinhaler® is difficult in preschool children, and cromolyn is usually not used in this age group.

Beclomethasone dipropionate (Vanceril®) is a topically active steroid that is inhaled from a metered inhaler. Like cromolyn it is not a bronchodilator and can be used effectively and safely only in the wheeze-free child. When wheezing begins, oral prednisone must be substituted for beclomethasone.

STAGE IV

Oral corticosteroids are reserved for the final stage of therapy because of their well known side effects, especially that of growth

suppression. Here we are referring to the chronic use of oral steroids, not their use for 7-10 days in the management of the acute wheezing episode.

We begin prednisone giving a single daily dose (2 mg/kg) each morning. We increase this as necessary until the child is wheeze free. We then change to every-other-day therapy by tapering alternate-day doses. The steroids are tapered rapidly and to as low a dose as allowed by the clinical stage of the child. We continue to use inhaled beclomethasone as it will permit the use of lower doses of oral steroids. Steroids are not used as a single entity in the control of asthma.

OTHER CONSIDERATIONS

Adjunctive therapy starts with reducing irritants in the environment

by practicing house dust and mold control. Parents should stop smoking tobacco or at least not smoke while near the child.

Our goal is to have the child grow and develop normally. Physical and social activities are not limited until all other remedies have been exhausted. Support of the family and counseling can have dramatic effect on increasing compliance with the prescribed regimen, and by so doing significantly improve the child's daily functioning.

We have tried to build an asthma therapy program on a sound basis by treating the known pathophysiologic effects of the disease. A basic program such as this must be modified for each child and family. Even under the best of circumstances, the child may have wheezing episodes that require hospitalization.

A discussion of status asthmaticus will be undertaken in a subsequent article.

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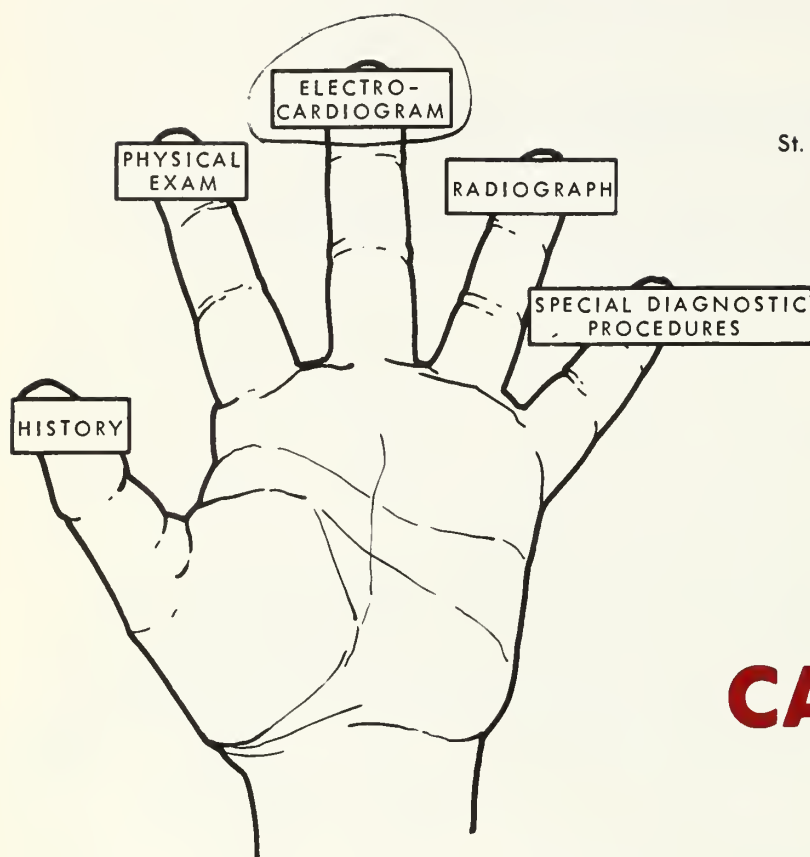
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THE FIVE FINGERS OF CARDIOLOGY

The Five-Finger Approach to Cardiac Diagnosis was conceived by W. Proctor Harvey, M.D., of Georgetown University, and further developed by J. Willis Hurst, M.D., of Emory University into its present form: The integration of all five approaches is diagrammed into a "fist" of cardiac diagnosis.

Periodically, THE JOURNAL will present a "finger of cardiology" as a self-assessment, emphasizing current and innovative diagnostic and therapeutic principles.

A 69-year-old woman reports to the emergency room with an exacerbation of retrosternal chest pain, which has repetitively occurred over the preceding three days.

The electrocardiogram is illustrated on the opposite page.

Physical examination demonstrates a loud, holosystolic murmur, best heard midway between the left sternal border and the apex. The murmur is accompanied by a thrill. Sinus tachycardia and a loud summation gallop are noted. Rales are heard over both pulmonary bases. A murmur has never been heard in this patient.

QUESTIONS

- Interpret the electrocardiogram.
- What is the explanation for the new heart murmur?
- How would you prove your diagnosis?

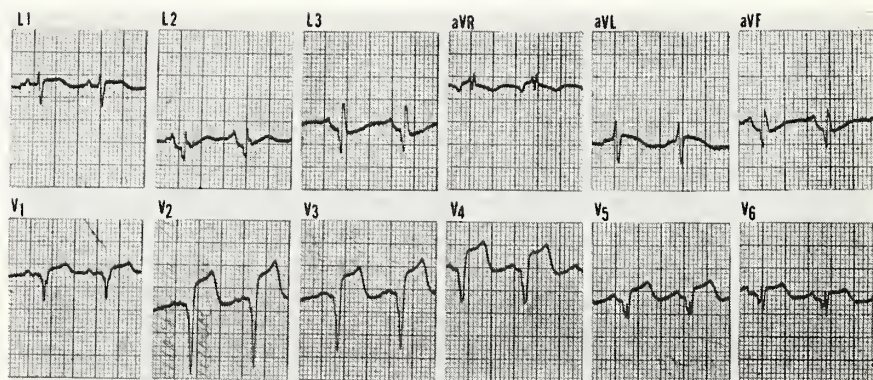
A Self-Assessment

ANSWER

The electrocardiogram demonstrates an acute anterior myocardial infarction, characterized by marked ST-segment elevation in the anterior or precordial leads. That the infarction is more than a few hours old (probably two or three days old at least) is suggested by the prominent QS complexes in the same leads. An old inferior myocardial infarction is indicated by the Q-waves inferiorly, but without acute ST changes in leads 2, 3 and AvF.

A new heart murmur develops in the setting of acute myocardial infarction in three situations: 1) acute ventricular septal perforation; 2) acute mitral regurgitation due to ruptured papillary muscle; and 3) acute mitral regurgitation due to papillary muscle dysfunction.

It is possible to clinically differentiate these conditions. First, locating the myocardial infarction by ECG is often helpful. Whereas acute ventricular septal perforation may occur with either an anterior or inferior infarction, acute mitral regurgitation due to papillary muscle rupture almost invariably occurs in association with inferior infarction; but papillary muscle dysfunction occurs more commonly in association with anterior wall infarction. The reason for this differentiation is that the posterior papillary muscle receives a single blood supply from the single artery supplying the posterior wall of the heart. Thus, infarction of the posterior myocardium also may result in posterior papillary muscle infarction and consequent rupture. In contrast, the anterior papillary muscle receives a dual blood supply, from both the left anterior descending and left coronary arteries. Infarction of the anterior papillary muscle is, thus, less common. However, large anterior wall infarctions commonly are associated with dysfunction



tion of the ischemic anterior papillary muscle.

An extremely important physical finding is the palpable thrill. This nearly always indicates that the murmur is acute ventricular septal perforation. The mitral regurgitation associated with papillary muscle dysfunction is rarely of sufficient severity to result in a thrill. Patients are so desperately ill with rupture of the papillary muscle, and their cardiac output so seriously depressed, that the murmur is not loud nor forceful enough to be accompanied by a thrill. Thus, the physical findings strongly suggest acute ventricular septal perforation.

Two excellent, noninvasive tests are available for differentiating between these conditions: echocardiography and radionuclide scanning. The M-mode echocardiogram should demonstrate a flail leaflet if the papillary muscle has ruptured. A cross-sectional echocardiogram often demonstrates an "aneurysm" of the ventricular septum, with the septum bulging toward the right ventricle, when the

septum is infarcted, in association with acute septal perforation. Such an abnormality was recorded in this patient. The flail mitral leaflet, if present, would also be depicted by cross-sectional echocardiography. Radionuclide scanning can confirm a left to right shunt across the ventricular septal defect.

Alternately, bedside Swan-Ganz catheterization could be performed to differentiate between the conditions. A step-up in oxygenation from the right atrium to the pulmonary artery would indicate a left to right shunt, with oxygenated blood passing from the left ventricle into the right. On the other hand, recording a prominent V-wave in the pulmonary capillary wedge pressure would indicate significant, acute mitral regurgitation.

The physical findings, the cross-sectional echocardiogram, and the Swan-Ganz findings of a significant step-up in oxygenation all confirmed that this patient was suffering from acute ventricular septal perforation secondary to her acute anteroseptal myocardial infarction.

Mechanisms of Hypercalcemia in Malignancy

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HYPERCALCEMIA affects multiple organ systems and induces a variety of pathologic events that may be more immediate threats to life than the underlying disease itself. The accompanying *table* summarizes the possible causes of hypercalcemia. The most common cause of hypercalcemia in the general medical population is malignancy. The purpose of this article is to review the possible mechanisms of hypercalcemia in malignancy.

In patients with known metastatic bone involvement, hypercalcemia is ascribed to the release

of calcium and phosphate due to osteolysis by tumor metastasis. Tumors commonly associated with hypercalcemia and metastatic bone involvement include carcinoma of breast, bronchus, kidney, thyroid, ovary and colon.¹⁻⁵ With each type of cancer, there is no obvious correlation between the extent of clinically detectable bone involvement and the development or degree of hypercalcemia. Some recent studies indicate that the manner by and rate with which bone is destroyed may be more important than the apparent degree of bone involvement by tumors.

When **metastatic bone disease is absent**, tumors may produce hormone-like substances, which presumably alter bone metabolism with release of calcium. If the rate of release of calcium from bone exceeds renal excretion, serum levels will rise. The resulting hypercalcemia then activates homeostatic mechanisms to restore serum calcium concentration toward normal through the release of thyrocalcitonin and the suppression of parathyroid hormone secretion. If these homeostatic mechanisms are inadequate, a spiral of increasing calcium levels results because of the effects of hypercalcemia on the kidney; hypercalcemia directly decreases glomerular filtration rate, which decreases urine output and calcium

excretion. Concomitant anorexia and vomiting further reduces filtration rate by leading to volume depletion. A vicious cycle takes place, and the full blown syndrome of hypercalcemic crisis results.

1. Parathyroid hormone-like substance: A variety of malignant neoplasms are capable of secreting parathyroid hormone-like substance (PTH-like substance). Squamous cell carcinoma of the bronchus and hypernephroma account for more than 50% of such cases.⁶⁻⁸

PTH-like substance functions in the same way as parathyroid hormone: increased mobilization of calcium from the skeleton; increased gastrointestinal absorption of calcium; increased renal reabsorption of calcium; and decreased renal absorption of phosphate.

Evidence for the production of PTH-like substance includes the following observations. First, PTH-like substance has been extracted from tumor tissue⁹ and has been detected in cancer tissue by immunofluorescence.¹⁰ Second, production of PTH-like substance by a primary hepatoma¹¹ and by hypernephroma^{2,12} has been documented by arteriovenous gradients across these organs. Third, specific production of PTH-like substance by renal cell carcinoma in tissue

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culture has been demonstrated.¹³ Levels of PTH fragments have been found to be higher in patients with primary hyperparathyroidism than in those with malignancy.^{14,15} Furthermore, for a given serum calcium concentration, PTH levels are higher in the former group than in the latter group.¹⁴ Discriminative analysis shows an overlap between the two groups of only 7.7%.¹⁵ These studies suggest a possible way of separating ectopic from primary hyperparathyroidism, but caution in interpretation is warranted in light of a recent report in which 35% of patients with hypercalcemia and malignancy had coexisting parathyroid adenoma or hyperplasia.¹⁶

2. Prostaglandins (PGE₂): High concentrations of PGE₂ are found in the primary tumor masses and in their venous drainage. Several clinical studies intimate a role for prostaglandins in cancer patients with hypercalcemia.¹⁷⁻²¹ Further evidence for prostaglandin alteration of calcium dynamics was noted by Robertson, *et al.*^{19,22} These investigators studied 21 cancer patients who had normal PTH-like substance. Eleven patients were hypercalcemic; four of these patients had elevated PGE₂ levels.

A more fundamental question, however, is whether arterial levels in patients ever reach sufficient concentration to affect bone. Infusion of prostaglandins has not consistently produced hypercalcemia.^{23,24}

3. Vitamin D-like sterols: Vitamin D-like sterols have been identified in carcinomatous breast tissue and in circulating blood. These sterols have hypercalcemic activity and are osteolytic in vitro.²⁵ Several breast cancer patients have been described who presented with biochemical features of Vitamin D intoxication.²⁶⁻²⁸

Causes of Hypercalcemia

1. Malignancy
2. Primary hyperparathyroidism
3. Drug induced hypercalcemia
 - Thiazides
 - Calcium containing antacids
 - Calcium containing antacids plus milk
 - Steroids
 - Vitamin D
 - Calcium
4. Thyrotoxicosis (occasionally)
5. Sarcoidosis (occasionally)
6. Immobilization (rarely)
7. Paget's disease (rarely)
8. Acute adrenal insufficiency (rarely)

4. Osteoclast activating factor (OAF): Recent studies revealed that bone resorption can result from the production of a diffusible substance within the bone by metastatic tumors. This substance was designated as osteoclast activating factor. Experimentally, the investigators were able to demonstrate osteoclastic resorption of bone in proximity to and at some distance from tumor masses within bone.²⁹ After implantation of squamous cell carcinoma cells into the femurs of rabbits, osteoclast activation appears to result from the production of a diffusible substance which affects cells over a wide area. Documentation of osteoclastic proliferation and bone resorption in clinical case material awaits verification by future studies.

In multiple myeloma or Burkitt's lymphoma, the neoplastic cells are able to produce a soluble factor similar to OAF.³⁰

5. Miscellaneous causes: In addition to the hormonally mediated mechanisms, several other mechanisms may contribute to negative balance in cancer patients without bone metastasis. Hypercitrinemia occurs in some patients with cancers; citrate, by chelating ionized calcium, activates parathyroid gland

secretion of PTH.³¹ The mechanism alone should not induce a hypercalcemic state, but may do so if the patient is immobilized for any extended length of time³² due to general debility, fractures, or pain.

CONCLUSIONS

This review has described possible roles of various hormones in the genesis of hypercalcemia associated with malignant neoplasm. It is hoped that further study will clearly define the causal relationships between abnormal serum levels of hormones and hypercalcemia so that specific therapeutic modalities can be developed.

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The Cummins Engine Company Stop Smoking Program

G. H. MILLER, Ph.D.
Edinboro, Pa.
JOHN S. RODWAY, M.D.
Columbus, Ind.

A UNIQUE PROGRAM to assist employees to stop smoking permanently was recently inaugurated at Cummins Engine Company in Columbus, Ind. The program called the SOS Stop Smoking Clinic consists of a one-year course designed to train smokers to "kick" the habit.

Cummins Engine Company agreed to the plan because of top management's concern for the health of their employees. Statistics show that smokers consistently have higher rates of disease and earlier deaths than non-smokers. Therefore, it was believed that a stop smoking program would improve the health of employees and increase fiscal savings by the company because of reduced absenteeism and fewer hospital bills.

The program was started with the help of Mr. Ted Marston, Cummins' Vice-President Corporate Action, and Dr. Wayne Richmond and Dr. John S. Rodway of the Columbus Occupational Health Association (COHA). The physicians on the COHA staff have been very supportive in helping employees to stop smoking permanently.

The SOS Stop Smoking Clinic was instructed by GHM, who previously had taught successful clinics in Erie County, Pa. In addition, he

has conducted extensive research on smoking and health.

To plan the clinics, GHM met with JSR to establish procedures for the Cummins project. A questionnaire was constructed, revised, and sent to Cummins employees to determine their interest in such a clinic. Forty-one employees returned completed forms. Two classes, with a total of 33 participants, began Aug. 20, 1979.

The clinic made use of GHM's recently published research, as well as newly acquired data from unpublished reports on his Studies on Smoking. The smoking cessation information was further amplified by films obtained from health-related organizations and by guest speakers.

The clinic used the "reverse peer pressure system," which involves the assistance of friends and the immediate family of the smoker. In addition, the "buddy system" was incorporated into the program to assist participants. Group counseling was provided during most of the meetings, especially during the later sessions. Individual counseling was given initially to all participants, and special sessions were arranged for those who were having difficulties in learning how to quit.

To determine whether or not the participants had stopped smoking, equipment was used to measure their carbon monoxide exhalation.

The clinic consisted of at least 15 sessions, starting with five the first week, three the second week, two the third week, and one the fourth week. Those sessions were followed by one session biweekly, three monthly, and one bimonthly.

A graduation ceremony is planned for August 1980 when the participants who have stopped smoking for a full year will be given certificates to reward their accomplishments. Members of the clinic are encouraged to reinforce their desire to remain former smokers by forming their own support groups and having additional monthly meetings.

RESULTS

After 4½ months since the clinic began, the following results can be reported for the 33 participants:

- 23, or 70%, had stopped smoking.
- 6, or 18%, were still trying to stop smoking.
- 4, or 12%, had gone back to full-time smoking at their previous levels without any attempt to return to their non-smoking behavior.

The most resistant participants from the standpoint of success were those who had been previously hypnotized and those who had smoking spouses.

Upon completion of the one-year non-smoking period in August 1980, a more detailed report will be prepared for THE JOURNAL.

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Dramatically Improved Outcome Of Extremely Low Birth Weight Infants:

Experience in Indiana in 1977

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THE OUTLOOK for most premature infants, especially those infants weighing less than 1,500 grams, was extremely bleak as recently as the early 1960s. However, nearly every major report concerning the mortality and quality of survival of premature infants during the past 10 years has shown a dramatically improved outlook.¹⁻³ The most impressive improvement has been the dramatic decreased incidence of cerebral palsy in premature infants.

Thus, the outlook, both in terms of survival and quality of survival, for infants weighing more than 1,000 grams is excellent. However, during the past 10 years, there has been considerable concern about the quality of survival of extremely low birth weight infants, i.e., less than 1,000 grams (2 lbs, 2 oz). Therefore, we thought it worthwhile to review those studies from this country and others concerning the mortality and follow-up of infants less than 1,000 grams and to present results from the state of Indiana for these critically ill infants.

Twenty-five of the 56 infants survived, and all of the infants were followed in the Newborn Follow-up Clinic. Of the 25, three infants died before six months of age and five infants were lost to follow-up during the first year. The remaining 17 infants were followed to 10-18 months corrected age (13-21 months after birth). The average number of visits to the Follow-up Clinic for each patient was four. Infants who had more problems were seen more often. Nine infants were normal at a corrected age of 10-12 months with a developmental quotient greater than 80. Six infants were mildly abnormal with a developmental quotient of 51-79. Two infants were moderately to severely abnormal with a developmental quotient of 30-50. Two of the abnormal infants had microcephalus. One infant had hydrocephalus that was arrested and did not need shunting. Of the 25 infants, three had ROP; one infant with severe ROP died at six months; one infant with mild ROP had resolution of the disease; and the only survivor with ROP is moderately retarded.

Thus, in this series of critically ill extremely low birth weight infants who were considered hopeless as recently as five to 10 years ago, survival rate was 45%; 53% of the survivors are normal, 35% mildly abnormal and 12% of the infants moderately or severely abnormal (Table 3).

DISCUSSION

There is no controversy that infants weighing between 1,250 and 2,000 grams have an excellent chance of surviving with normal development. Our own survival statistics for infants weighing 1,000 to 1,500 grams are 80% and from 1,500 to 2,000 grams, 89% (Table 1). All studies that have been reported in the past five years for

premature infants of this size and cared for in good newborn intensive care units show excellent quality of survival, with 75-95% of the infants being normal. However, there is still concern about the quality of survival of extremely low birth weight infants. Recently Stewart, *et al*⁵ have reported follow-up of 48 infants weighing 1,000 grams or less at birth from 1966 to 1975 and cared for in a newborn intensive care unit. These infants were followed until an age of 15 months to eight years. Seventy-

MATERIALS, METHODS

The study includes all infants less than 1,000 grams admitted to the James Whitcomb Riley Hospital Newborn Intensive Care Unit at the Indiana University Medical Center from Jan. 1, 1977 to Dec. 31, 1977. Eighty-five per cent of admissions to this Newborn Intensive Care Unit are transferred from hospitals outside of the University complex. Fifteen per cent of the infants are admitted from University Hospital and Wishard Memorial Hospital. During this period, 6% of the admissions (56 infants) had a birth weight of less than or equal to 1,000 grams and are included in this study. The care of all infants was under the supervision of one of three neonatologists. Those infants transferred from outside the University complex were transported by the Riley Hospital neonatal transport team. Decisions concerning the use of ventilator support were made after consultation with the family, whenever possible.

After discharge, infants were followed by the newborn follow-up program at the James Whitcomb Riley Hospital for Children. This included periodic visits during the first 1½ years of life (two to eight visits). The results of the detailed neurologic examination by the developmental pediatrician and Bayley Scales of Infant Development administered by the pediatric psychologist in the follow-up program at a corrected age of one year (approximately 16 months after birth) are presented here. Any infant with abnormal neurologic examination, hydrocephalus, retinopathy of prematurity (ROP) — formerly termed retrolental fibroplasia (RLF), or developmental quotient on the Bayley examination of less than 80 — was considered abnormal.

RESULTS

Eight hundred ninety-two pa-

TABLE 3

Summary of Outcome

56 Infants \leq 1000 Gm
James Whitcomb Riley
Hospital for Children
January-December 1977

Survival	45%
Quality of survival	
Normal	53%
Mildly abnormal	35%
Moderately or severely abnormal	12%

eight per cent of the survivors had no abnormalities, 15% had minor abnormalities "unlikely to interfere seriously with normal life" and only 7% of the infants had major handicaps. Other reported studies including our own results in Indiana confirm the excellent results of Stewart: When infants 800-1,000 grams receive excellent obstetrical care, appropriate resuscitative efforts in the delivery room, and are cared for in a newborn intensive care unit staffed by competent physicians, nurses and respiratory therapists, the majority of surviving infants are normal and only a few are seriously abnormal.

TABLE 1

Birth Weight and Outcome of Newborn Intensive Care Admissions

*James Whitcomb Riley Hospital for Children
January-December 1977*

Birth Weight (gms)	# of Admissions	% Total Admissions	# of Deaths	% Survival	% Total Deaths
<501	0	—	—	—	—
501-1000	56	6.3	31	44.7	21.7
1001-1500	118	13.2	24	79.7	16.8
1501-2000	112	12.5	12	89.3	8.4
2001-2500	112	12.5	11	90.2	7.7
>2501	494	55.3	65	87.0	45.4
TOTAL	892	100	143	84.1	100

tients were admitted to the Newborn Intensive Care Unit (NBICU) in 1977 (Table 1). One hundred eighteen (13.2%) of these infants had a birth weight of 1,000 to 1,500 grams and 80% of these infants survived. Fifty-six infants (6%) weighed 500 to 1,000 grams and 45% of these infants survived. Perinatal complications including prolonged rupture of membranes,

preeclampsia, abruptio placenta and amnionitis were seen in 46% of the deliveries of infants less than 1,000 grams. As can be seen in Table 2, infants under 1,000 grams with a one-minute Apgar less than 2 or a five-minute Apgar less than 3 had an equal chance of surviving and being normal on follow-up as the infants with higher Apgar scores.

The Apgar score is not helpful in

predicting outcome of very low birth weight infants. Among infants who received Apgar scores less than 2 at one minute, 40% survived, and there was an equal number of normal and abnormal infants. Of those infants with an Apgar score of 3 or less at five minutes, 50% survived and 60% were normal. These data, which support data from numerous other studies, demonstrate that the one-minute or five-minute Apgar score cannot be used in the extremely low birth weight infant to predict outcome. Thus, decisions concerning aggressiveness of resuscitation usually cannot be made in the delivery room in the extremely low birth weight infant, except for those with severe congenital anomalies. If the extremely low birth weight infant is to have a chance for normal survival, appropriate resuscitative measures must be instituted immediately in the delivery room.

There are, of course, still serious questions and problems which need to be addressed. All of the infants are not normal and a few of the infants are still severely abnormal. In addition, the cost of newborn

TABLE 2

Correlation of Apgar Score and Outcome of Infant

*James Whitcomb Riley Hospital for Children
56 Infants \leq 1000 Gm
January-December 1977*

	Apgar < 2 at 1 min	Apgar < 4 at 5 min
Infants who died	17	10
Infants who lived	12	11
Normal infants	5	5
Abnormal infants	5	4
Infants lost to follow-up	2	2

intensive care is staggering. Pomerance has recently calculated that the average newborn intensive care unit costs for infants under 1,000 grams is \$40,000 for each survivor.⁶ However, if one questions the ethical or financial aspects of providing intensive care to these small infants, one must realize that:

1) If the infants are not cared for properly, although many will die, many will still live as in the pre-newborn intensive care era and have severe neurologic handicaps. 2) The cost of institutionalization of severely handicapped infants for life is overwhelming. It is much more effective to provide quality obstetrical and neonatal intensive care for these infants than to undergo the financial burden of caring for them in an institution. 3) All medical care, especially intensive care, is very expensive.

However, if one seriously questions the financial validity of newborn intensive care for these small infants, then one must also question *all* intensive care for critically ill humans (adults, children and neonates) where the risk of death is on the order of 40-50%. In addition, the quality of survival of infants in newborn intensive care is much greater than that of comparable adult intensive care units. For example, a recent study⁷ showed that, of the 226 adults admitted to a university surgical intensive care unit, only 27% were alive one year after admission. In addition, only half of the survivors were functioning in society one year later. This must be compared with the expected 70-year survival of extremely low birth weight infants who survive neurologically intact, as most of them do.

What does all this mean to the family practitioner, pediatrician and obstetrician?

- The obstetrical management of extremely low birth weight fetuses

is extremely important in the outcome of the infants. For example, infants who are breech (and many extremely low birth weight infants are breech) have a much higher mortality and morbidity if born by vaginal delivery than by C-section. Therefore, serious consideration must be given to performance of C-section for very low birth weight and extremely low birth weight infants who demonstrate abnormal presentation.^{8,9}

- If a good outcome is to be expected and aggressive neonatal management is to be carried out, the obstetrical management of very low birth weight and extremely low birth weight fetuses must not jeopardize the outcome of the infant. Therefore, obstetrical measures to prevent fetal asphyxia must be utilized (fetal monitoring, maternal positioning, appropriate fluid administration, maternal oxygen and continuous use of potentially depressant drugs during labor).

- The first few minutes and hours of life are critical to the outcome of extremely low birth weight infants. As discussed above, a low Apgar score in extremely low birth weight infants does not predict a poor outcome. Appropriate resuscitative measures must be carried out if these infants are to have a reasonable outcome.

- Extremely low birth weight infants are probably the most difficult and challenging patients for the neonatologist. Serious consideration should be made whenever possible for the transfer of the mother before delivery to a tertiary perinatal center that includes neonatal intensive care. When this is not feasible because of rapidity of labor and delivery, the infant should be stabilized and transferred by an experienced neonatal transport team as soon as possible to a newborn intensive care unit.

- Although the outcome of extremely low birth weight infants has improved dramatically during the past 10 years, the risk of death, intracranial hemorrhage, mental retardation, cerebral palsy, bronchopulmonary dysplasia (oxygen and respirator toxic lungs), retinopathy of prematurity and, of course, death are still significant.

The family should be provided reasonably optimistic, but yet realistic, estimates of the child's chances of survival and of the quality of survival. These are usually the most difficult times in any parent's life. It is the responsibility of the physicians involved to work closely with the parents in making decisions concerning the use of respirators and, when the chances of survival or a reasonable quality of survival are nil, to work with the family concerning their wishes for withdrawing intensive life-sustaining therapy.

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AUXILIARY REPORT

Charlotte (Mrs. Abner P.) Bennett
President, ISMA Auxiliary

The completion of Charlotte's Web, symbolic theme of our 1979-80 Auxiliary year, will take place April 22-24 during the 36th annual House of Delegates meeting at the Executive Inn, Evansville. The theme has envisioned the strands of a web reaching out to each auxiliary, touching them and providing avenues of communication between the county and state.

The convention will be flavored with Hoosier hospitality and spiced with a bit of the South in the person of a Southern lady, Mrs. Ben Johnson Jr., our national president and keynote speaker.

Our Wednesday dinner, to which spouses and guests are invited, will highlight the convention. Our thanks to Mr. Randy Jones of Intrav for arranging a special weekend trip, details of which will be announced during the dinner.

Vanderburgh-Southwestern county auxiliaries, under the leadership of Mrs. Ronald Waddell, Mrs. James Robertson and Mrs. Ken-

neth Rudolph, will host the convention. They have worked many hours to insure that the delegates' stay will be enjoyable.

During the past year, the board members and I have maintained contact with county auxiliaries by frequent mailings, telephone calls and personal visits. A key aspect of this internal communication effort has been our Auxiliary newspaper, *Hoosier Doctor's Wife*, edited by Marcia Laker.

Our communication with ISMA was strengthened by Auxiliary participation in their meetings and working with their commissions. Special staff support was provided by the appointment of Rosanna Iler as liaison representative to the Auxiliary.

The sharpening of Auxiliary leadership skills as a concern of the ISMA was demonstrated by underwriting the attendance of the Auxiliary president and president-elect at the February AMA leadership conference in Chicago. Auxiliary's way was smoothed immeasurably

by Dr. Arvine Popplewell, Mr. Don Foy and the ISMA staff. Our efforts also were enhanced by having a direct input into our national organization by the presence on its board of Mrs. Philip Smith, our North Central vice-president.

Although we have stressed all year the importance of each auxiliary's and each county's contribution, all has been done in partnership with the physicians of Indiana. We have worked together in trying to improve health in local communities. We must never lose sight of our main reason for existence—we are an auxiliary to a medical association.

During the past year, I found my admiration for Hoosier auxiliaries growing. They are competent, creative people with a deep sense of service. I deem it special to be counted among them. I shall cherish for the rest of my life the honor of having served as president. To all of you, Abner and I offer our heartfelt thanks for a memorable year.



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When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

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ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

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FOR PATIENTS HABITUATED TO STRONG PURGATIVES: Two rounded teaspoonsful of Perdiem™ in the morning and evening may be required along with half the usual dose of the purgative being used. The purgative should be discontinued as soon as possible and the dosage of Perdiem™ granules reduced when and if bowel tone shows lessened laxative dependence.

FOR COLOSTOMY PATIENTS: To ensure formed stools, give one to two rounded teaspoonsful of Perdiem™ in the evening with warm liquid.

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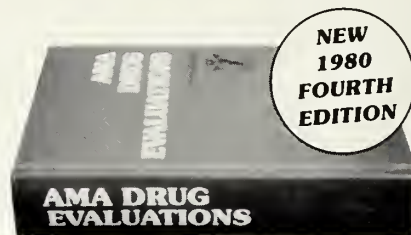
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Court Action

Employee May Sue Company Physician

An employee may maintain a malpractice suit against his company physician for negligent treatment of a work-related injury, an Indiana appellate court ruled.

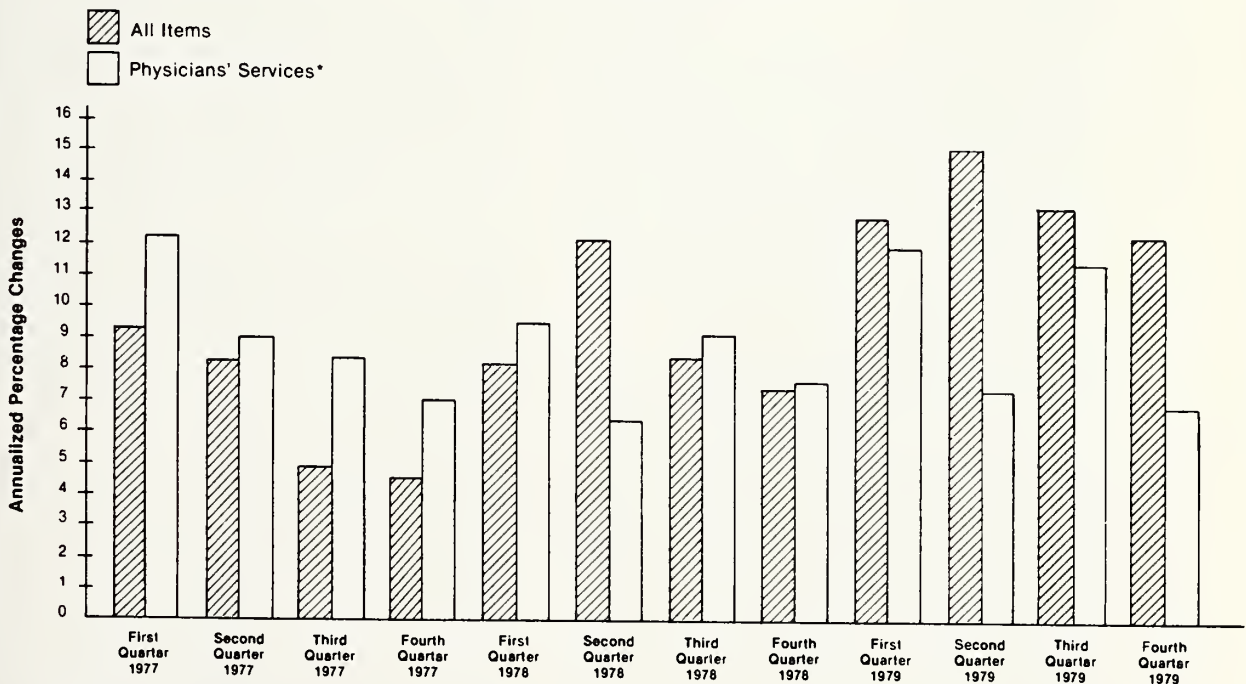
The employee, a millwright, fractured his right tibia and fibula while working in a steel mill. He was taken to the company's medical clinic, where he was treated by a company physician. The physician's treatment of the broken leg culminated in surgery in which a compression plate was inserted in the leg to facilitate the healing process and strengthen the damaged limb. The employee later began experiencing pain in his right leg. An examination of the limb revealed that the tibia had

again been fractured. The employee then filed a malpractice suit against the physician, alleging that his negligence had caused the second fracture. A trial court granted the physician's motion to dismiss on the ground that the employee's sole remedy was workmen's compensation.

Reversing that decision, the appellate court adopted the rationale of a federal appellate court in a similar case. The court said that a company physician was an independent contractor within the meaning of the workmen's compensation law. The court said it found nothing in the law that indicated that it was intended to shield a physician from malpractice liability.—*Stevens v. Kimmel*, 394 N.E.2d 232 (Ind. Ct. of App., Sept. 20, 1979)

Courtesy of THE CITATION, Feb. 1, 1980.

Annualized Percentage Changes in the CPI All Items and Physicians' Services Components by Quarter — 1977 to Present



Graph compares changes for the Consumer Price Index (CPI) all items and physicians' services components. In the last quarter of 1978 the annualized percentage change in the physicians' services index was slightly greater than the annualized all items change. For each quarter of 1979 the annualized percentage increases for all items surpassed the increases in physicians' services.

—CPI REPORT, Dec. '79

NATIONAL HEALTH POLICY:

What Direction Should the Nation Take?



Otis R. Bowen, M.D.
Governor
State of Indiana

The following speech was prepared for the Platform Committee for the 1980 Republican National Convention.

Mr. Chairman and members of the Republican Platform Committee, it is an honor for me today to present to you my thoughts regarding the future of our nation's health policy. In my unique position as the nation's only physician governor, I find many of the health care policy programs being advanced by Democrats both inside and outside of the present Administration to be of serious concern.

As a physician for 38 years, and active participant in the delivery of health care services for 30 years, I believe that I have some ability to recognize the shortcomings and deficiencies in that system, as well as the tremendous advancements which have occurred in the field of health. Additionally, I have witnessed firsthand the changing demands of health care consumers. The new discoveries, cures and techniques in the field of health are a tremendous source of pride for all Americans and especially for me, even though I am no longer in the active practice of medicine.

Now in my eighth year as Governor of the State of Indiana, I have been exposed to a completely new aspect of health care and its problems. Facing the pressures of government finances, as well as the disastrous impact of inflation on individuals, has been a sobering

experience. Perhaps there is no greater competition for government dollars than in the human service area. Numerous times a governor is called upon to referee disputes between consumers and providers and their competing demands. Today we face increasing competition for these human service dollars in the form of competition among health care programs.

It is vital for each of us to search for viable alternatives which will both control the inflationary spiral as it affects health care costs in this country and to meet the increasing demands of the health care consumer without destroying the private initiative and competition which has provided our nation with one of the best health care systems in the world.

From this dual perspective, I would like to share with you my thoughts about the health policy of this nation—where it is now and what direction it should take in the next decade.

The threshold of the 1980s on which we stand today can be viewed as the turning point with respect to this nation's future health policy. Over the past several decades we have witnessed increasing federal activity in the health care field. I am in no way condemning these programs—on the contrary, several have dramatically improved both the quantity and the quality of health care in this country. For example, one of the first modern federal programs addressing the issue of health care dates back to 1946 when the Hill-Burton Program

began. In essence, this program provided construction money for needed new hospitals and provided for a state survey planning process by which these funds could be distributed to meet unfulfilled needs in local communities.

In the mid-1960s came the enactment of Medicaid and Medicare—one of the first programs to involve government as a third-party payor in the area of individual health costs. As we all know, these two programs were designed to relieve part of the health care cost burden from the poor and elderly of our nation.

In 1974, we saw Congress taking an increasingly active role with respect to health planning in the country by the passage of Public Law 93-641 entitled the 1974 Health Planning and Resources Development Act. Few issues have ever united all of this nation's 50 governors; however, opposition to this program did just that. The primary concern to most governors was that it destroyed the traditional governmental partnership among federal, state and local governments through their duly elected officials. It substituted a combination of a federal government agency (at that time the Department of Health, Education and Welfare) and state and local quasi-public bureaucratic creatures. Members of these agencies were neither elected nor appointed in any rational fashion that would assure accountability through the most fundamental public policy-making device of our nation—that of free election. The recent 1979 amendments to this act in no way addressed this serious deficiency in the law. This health planning program leads to the turning point of our national health policy.

Although the issue of health care has not captured the headlines on a daily basis, competing with such national issues as energy, inflation and foreign affairs, it is still a current issue and perhaps is the most personal one we shall ever confront.

The White House and Congress have proposed numerous programs during the last three years, any one of which would totally and completely redesign our health care delivery system as we know it. Although there are differences among the various plans which would purport to equalize the availability of health care, lower the cost to the consumer and provide a third-party payor mechanism for each American, the truth is that these Democrat plans in effect “nationalize” one of our largest American industries and in varying degrees remove the sacred fundamental right of individual freedom of choice.

Certainly there are problems involving health care in this country. Here are just a few:

1. Unequal, sometimes narrowly limited, access to health care—particularly in rural and some highly urbanized areas.

2. Maldistribution, and possible shortages, and uncoordinated activities of health professional and technical personnel.

3. Rapid and disproportionate increases in health care costs.

4. The plight of the 16 to 20 million Americans who are considered medically indigent.

5. Lack of individuals' financial resources to offset the effects of catastrophic illness and injury.

It is absolutely necessary that Republicans immediately address themselves to these problems by proposing meaningful solutions which will preserve the health care system which historically has served all of us well. We must improve its present deficiencies without charting a course which would present much greater problems in the future. I believe that both the Carter and Kennedy versions of National Health Insurance would do just that, by delivering rationed health care at an enormous price to the taxpayer.

I will not attempt in this presentation to cite the shortcomings I perceive with each of these plans. It is far more important and beneficial for this committee to consider positive steps which can be made to strengthen our current system of health care.

Historically, the goals of our national health policy have been based upon two principles—first, “quality care” and secondly, “access” to such care. The obvious evidence of the public's strong traditional support for quality care can be quickly demonstrated by the continued public support for ever-increasing medical research; its enduring press for the ultimate defeat of all human illness and affliction; its vigorous attack upon the malpractice of every one of the health care professionals; and by the degree to which the American health care field has been broadened, deepened and specialized.

Clearly a second traditional public goal has been one we refer to as “access”. The sufficient quantity of American health care has always been a public goal of our nation—but never have I heard a patient support any desire for “quantity” above a need for “quality”. Quite literally, the public wants *more* and *better* health care: not *more* and *poorer* care! In response to quantity needs, our nation has increased its number of health professionals and through the increased use of para-professionals' skills—such as those involved with emergency medical services—we have sought to make better use of the increased specialization we have developed. I do not perceive the public to be retreating from either of these two

historic goals for our national health policy or placing cost consideration *paramount* to both.

If then, we are to consider a new direction for our nation's health care, it must be a policy that will better meet these goals.

The first question which should be addressed is: Is there a basis for the belief that increased federal control of our national health care system will result in improvements to that system? Do we have a proven track record of experience in existing federal programs which attempted to provide and finance health care to individuals? Clearly, as an example, our Medicaid experience does not provide proof that federal health planners can properly estimate costs, consistently deliver quality services, or even protect the taxpayer from fiscal abuse of the program.

The public has witnessed both Medicaid and Medicare being "adjusted" in coverage for "cost" reasons, raising doubts both as to the quality of the care delivered, and the ultimate stability of coverage. Medicaid has become an additional burden upon middle income taxpayers, as well as a bureaucratic quagmire, that threatens to totally pulverize whatever semblance of a traditional federal-state relationship that once might have existed. Finally, if cost is now to become the *controlling* factor in our nation's health care policy, is there any shred of evidence that a federally dominated program of *any* type has proven to be *better* and *cheaper* than the alternative it replaced?

I submit that it is rare in our history as a nation that we can point to a condition that was *improved* because the federal government took it over!

That observation being made, there is, however, no doubt that American health care is a legitimate national issue. Clearly there is a role—and a major role at that—for well-reasoned and properly structured federal and state public policies. But, in my mind, equally clear is the fact that this national role must not be one of the federalization of America's health care system, flying under a "flag of convenience" entitled "National Health Insurance".

There are specific areas in the field of health care in which the federal government has traditionally been involved and which they should continue to support. These include the fields of scientific research and discovery supporting other public and private efforts. Disease control and prevention is unquestionably a national priority. Research is costly and time consuming, but one of the *most successful* programs to combat the increasing cost of health care is to prevent disease.

Closely tied to the research function is the training of health professionals. The federal government has a role in providing assistance

to maintain the high standards of quality we can rightfully expect from our health professionals. Grants and loans to both medical schools and students will go a long way to insure that adequate numbers of trained health personnel are available in future years.

With all of the recent conversation about health cost containment, I would like to suggest a self-examination for the federal government. Bureaucratic red-tape, overlapping and duplication of programs and the need to submit mountains of state/local plans, reports and surveys associated with today's federal health programs have drastically added to this nation's health bill. Many of these costs are traceable directly to federal rules and regulations which are often promulgated with the underlying intention of saving money!

The most important role which I would envision for the federal government in the nation's health policy would be to support and encourage soundly designed health care cost containment structures with shared public and private sector responsibilities. This joint approach offers the most immediate hope for arresting the *cost* of health care—without sacrificing the *quality* of the care delivered. You may all be somewhat familiar with the nationwide Voluntary Effort activity which has been launched to contain health care costs. In Indiana, we have an active committee which has joined this effort. However, I would like to point out that efforts such as this one have been on-going in our state for almost two decades. The most significant voluntary cost containment effort, in which hospitals throughout the state participate, is the Indiana Rate Review System.

The latest figures available, for 1977, show that the average cost of hospital services in Indiana was \$153.89 per patient day, or \$24.32 *less* per day than the national average. This average cost per patient day figure for Indiana is lower than any surrounding state.

Based on the difference between costs under the voluntary system in Indiana and the national average, patients in Indianapolis hospitals are saving about \$40 million annually. Across the state, Hoosiers are saving \$160 million each year on costs. Those are very significant figures!

The 1978 Medicare Directory of Prevailing Charges, published by the Department of Health, Education and Welfare, shows that Hoosier doctors charge their Medicare patients anywhere from 10 to 30 per cent less than the national average.

Indiana is basically no different than any other state in the union. These same activities could occur and proportionate savings could result in every state. All that one needs is a

cooperative atmosphere in which the health industry, health professionals, labor, business and government can work together for a single goal rather than competing with one another for dominance and control over the other, which so often happens if government establishes itself as the sole and primary problem solver.

We are led to believe by many individuals that the American public is demanding National Health Insurance. I would suggest that National Health Insurance is not what the people want. *Better* and *cheaper* health care is what they want! Every survey I have seen, if the polling was done with some semblance of objectivity, shows that 90 per cent of the people are highly satisfied or well satisfied with health care delivery as they now experience it.

Other fallacies associated with the concept of National Health Insurance include:

1. The claim that it will save money. Again, look at past history! Medicare and Medicaid—the original estimate of cost and how it has skyrocketed. Look at England's national health service costs—\$1,500 per person/year.

2. The claim that it will guarantee better service. If National Health Insurance is instituted, doctors now working 60-hour weeks will be working 37 to 40. Instead of seeing 25 patients per day, they will see 15—or if they see more—quality will go down. The waiting time and lists for elective surgeries such as hernias, varicose veins, tonsillectomies, etc., will inevitably be longer due to the need for prior review approval and the like.

3. The claim that National Health Insurance will provide better controls for government. That is true—but government control tends to institutionalize mediocrity, not encourage excellence and foster efficiency.

We should take tremendous pride in the private sector accomplishments which have guaranteed the delivery of health care services on a timely and professional basis. Our system of private health insurance is one of the best in the world, especially as compared to government insurance schemes. However, the private sector must not rest on its laurels—it must constantly seek ways to better address the health needs of consumers. Health care professionals must strive to deliver the best possible care while at the same time be fully aware of the cost and alternatives to any diagnostic procedures and treatments which they may prescribe. Any program which has as its goal a reasonable cost for the delivery of quality health care must provide a mechanism enabling the delivery system to place incentives for cost-conscious activities of health care providers, uniform accounting and rate review, capital expenditure and service controls

and methods to counteract the practice of defensive medicine which increases the cost considerably.

Health professionals, as well as individuals, must also recognize that prevention of illness and injury is much less expensive than treatment. Preventive medicine, through early diagnosis or through health education, or both, can make a major impact on the cost of health care.

Our national private health insurance industry is currently involved in studying and proposing changes in present insurance mechanisms which will assist in improving the health delivery system. Reconsideration of certain policy coverages pertaining to out-patient services is certainly a step in the right direction. However, I would list a few additional topics for consideration:

1. Guaranteed access to private comprehensive health insurance by all individuals and groups regardless of past or present health conditions. Individuals should be given a choice as to whether they purchase such a plan—no insurance program should mandate purchase.

2. Insurance policies should be readable so that the insured has full understanding of what he or she is purchasing.

3. Reevaluation of consumer cost-free plans must occur. The consumer must be well informed about his or her own health care expenses. If alternative forms of care or treatment are available, the consumer must be educated so that he or she may fully participate with the health professional in any required decision-making activity.

It is significant to point out that in countries where a strong competitive private insurance system has existed, national health insurance has not worked satisfactorily.

I believe that these improvements, coupled with certain changes in our present federal tax structure—for example, a proposed elder care income tax credit available to individuals who care for senior family members—will both improve our health care delivery system in this country as well as provide such quality care at a reasonable cost to the consumer.

This presentation attempts to point out that there are alternatives to the federalization of American health care, and such alternatives are eminently more desirable to consumers. The beginning of the 1980s is certainly not the time to abandon our previous commitments to freedom of choice, individual privacy and the principles of private enterprise. Republicans must take the leadership to protect the quality of our health care delivery system. If we fail to do so, we may never again have the opportunity.

BOOK REVIEWS

Reviews from the 'Kentucky Bicentennial Bookshelf'

"*David Wendel Yandell, Physician of Old Louisville*," Copyright 1978, and "*Luke Pryor Blackburn, Physician, Governor, Reformer*," Copyright 1979. Both books are by Nancy Disher Baird, the University Press of Kentucky. These are small, illustrated hard-bound books (114-128 pages, \$4.95 each). Each has reference notes. They are part of a project called "The Kentucky Bicentennial Bookshelf," sponsored by Kentucky Federation of Women's Clubs and Kentucky Historical Events Celebration Commission.

These books are little gems of their genre and, on account of historical continuity of the development of Kentucky and Indiana, they are of special interest to Hoosier physicians. Dr. Yandell (1826-1898) was graduated from the Louisville Medical Institute in 1846 (the year the Aesculapian Society of the Wabash Valley was founded) and then spent over two years in post graduate study in London and Paris, plus a medical congress in Vienna.

On entering practice with his father, Lunsford Yandell, he was soon a successful physician and surgeon. His grandfather, Wilson Yandell, was the first of six generations of physicians. Thirteen years later David joined the Confederate army, in which he had a varied career with high responsibility, including that of Medical Director of the Army of the West. After four years of war he returned to Louisville and renewed his practice. He also became professor of clinical medicine for two years and then professor of clinical surgery at the University of Louisville. He continued year after year to push for improving and enlarging the medical school—with success.

He also became a well known and excellent medical writer and editor (he founded the *American Practitioner and News*). He attended his first AMA meeting in 1850 and became a life member in 1855. In 1871, at San Francisco, he was elected president of the AMA. In 1879 he helped organize the American Surgical Association and was its president in 1890. He founded the Louisville Surgical Society in 1890.

Luke P. Blackburn (1816-1887) is of special interest because he became governor of Kentucky in 1879, but his public career was stormy.

While apprenticed to his uncle, Churchill Blackburn, to study medicine he had his first acquaintance with Asiatic cholera when it reached the Bluegrass in 1883. The account of this Lexington epidemic reads like a description of the bubonic plague in Europe in the 14th Century. After his two-year preceptorship Blackburn entered Transylvania University and attained his medical degree in March 1835, for which occasion he wrote an 18-page thesis on "Cholera Maligna." At age 19 he began practice in Lexington, but when cholera

appeared at Versailles, Ky., in August 1835, the local physicians became victims (some fled, also) and Blackburn went there to help out, and then remained there until 1844, when he moved to Frankfort, having served one term in the Kentucky House of Representatives. In 1846 he moved to Natchez, Miss.

In Natchez he soon assumed management of the city hospital and "hired his brother Henry and another young doctor to act as resident physicians and provide constant medical and nursing care." This led later (1849) to appropriation by Congress of \$600,000 for six Marine hospitals along the Mississippi. In Natchez Dr. Blackburn met another great plague, yellow fever, with a mortality rate of 30 to 50 per cent. In 1848 he was elected Natchez health officer and, although the cause of yellow fever was unknown, he established a quarantine station down river from the city and urged all citizens to clean up their property to eliminate "sources of miasma" such as standing water, rotting vegetation, etc.

Blackburn moved to New Orleans in 1858. In 1861, instead of enlisting in the Confederate army's medical corps, he became a civilian Confederate agent and information about him "during the first two years of the war is sketchy." Blackburn is said to have toyed with the idea of deliberately introducing yellow fever into the North by means of importing infected clothing into northern cities. Later, Blackburn was accused of employing germ warfare with Canada as a base. He underwent hearings at Toronto and was tried for violation of Canada's neutrality, but was acquitted. This was in October 1865. In this country, Blackburn was charged in absentia with murder, and testimony about him was elicited in the hearing concerning the plot to assassinate President Lincoln. This charge was never pushed, but neither is there evidence that it was withdrawn. The author states: "He probably was guilty of trying to use his knowledge to aid the Confederacy's desperate struggle against a superior force, but Blackburn certainly was innocent of murder. Only a mosquito can be held responsible for spreading the deadly yellow fever virus." Later, one newspaper, the *Cincinnati Gazette*, tried (1879) a smear campaign based on the above mentioned charges but Kentucky voters ignored it and elected Blackburn governor by the large Democrat majority since 1868.

As governor his chief accomplishment was prison reform, centered on the penitentiary at Frankfort, and he succeeded in changing it from a contract basis to the warden system. He is remembered in Kentucky as a great humanitarian.

When tired or discouraged by the vagaries of modern medicine, a browse in these books will enable the present-day physician to see our 20th Century advantages in a new and stronger light.

A.W. CAVINS, M.D.
Terre Haute
Gynecology

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgen deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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BOOK REVIEWS

The Courage to Live

Ari Kiev, M.D. Copyright 1979, Thomas Y. Crowell, Publishers, New York, N.Y. 148 pages, \$7.95.

This well written book is based on a survey of a national problem—suicide. Statistically, according to the author, the incidence of suicide varies because many cases are not reported; it is difficult to ascertain whether certain deaths are accidental or self-inflicted. Dr. Kiev says, "The most reliable figures place the number of suicides in the United States at between 25,000 and 50,000 per year . . . with the number constantly on the rise and with a figure of attempted suicides, (the figures) may run as high as 250,000 per year."

The consensus has been that the individual attempting suicide or actually accomplishing the act is a weak, disturbed and frustrated person who is not willing to live with existing conditions; he is thought of as a person who has the courage to die but not the courage to live. Although the incidence of suicides has increased in the past 20 years in all age groups, it has reached a figure of about 5,000 per year among 15- to 24-year-olds.



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Dr. Kiev, a practicing psychiatrist, has explored the serious aspects of the abnormal behavior of persons with suicidal tendencies and has, in this book, clearly explained the causes, preventive measures and treatment needed to control this national crisis.

Basically, suicidal behavior is the result of depression. This depressive illness can be produced by such factors as emotional crises, alcoholism, drug-dependent living, physical health problems, helplessness, apathy and despair. Depression is manifested by fatigue, insomnia, sexual disturbances, changes in appetite, pain, inability to work, hypochondria, stress and psychiatric behavior.

When the depressive state is noted early, adequate therapy is needed to prevent greater involvement. The chemotherapy used depends upon the practitioner's choice and the drugs with which he is most familiar in the tricyclic group. These drugs work by preventing the breakdown of serotonin, norepinephrine and dopamine, the so-called mood normalizing brain hormones involved in depression. These drugs are not rapid in action and progress determines the length of time and dosage needed. If no response is noted in two-four weeks, a monoamine inhibitor should be added to the treatment. If the previous symptoms are not noted but a state of anxiety complicates the picture, tranquilizers should be used. When acute symptoms of apprehension, excessive alertness, sweating palms, tachycardia and shortness of breath are noted, the drug should be discontinued as the state of relaxation noted is such a pleasant feeling that addiction can be forthcoming. Likewise, the taking of barbiturates for sleep should be observed very carefully because the need of increased dosage for satisfactory results can lead to drug dependence and later severe withdrawal symptoms.

Treatment of the depression state and the conservative stage, or Phase I, will often control disabling symptoms, and the patient can maintain usual daily activities. But when the condition becomes too chronic and suicidal tendencies become too prominent, psychotherapy (Phase II of treatment) should be considered. Such treatment, for the most part, requires a psychiatrist's consultation and, along with professional counselors and the family doctor, there is an excellent chance that the patient can be relieved of the depressive state, the abnormal patterns of behavior, the feeling of guilt—and the reversal of the thoughts of suicide to thoughts of "courage to live."

IRVIN W. WILKENS, M.D.
Indianapolis
Internal Medicine

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Asthma in Children

CONTINUED FROM PAGES 223-226

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223.**

- All but one of the following is a basic pathophysiologic mechanism of childhood asthma:
 - Atelectasis
 - Hypersecretion of mucus
 - Airway edema
 - Bronchospasm
- Reduction of the expiratory wheeze can be associated with:
 - Relief of obstruction
 - Reduction of expiratory flow
 - Airway edema
 - a and b
- The physical finding associated with mucus hypersecretion found most commonly is:
 - Suppression of breath sounds
 - Fine and coarse crackles
 - Expiratory wheeze
 - None of the above
- The development of large negative intrathoracic pressure can lead to:
 - Bronchospasm
 - Pulmonary edema
 - Air trapping
 - Atelectasis
- Air trapping occurs in what per cent of asthmatics with normal maximum expiratory flow volume curves?
 - 10
 - 20
 - 25
 - 33
- Hypoxemia in asthmatics is most commonly secondary to:
 - Hypoventilation
 - Shunt
 - Ventilation/Perfusion mismatch
 - Diffusion abnormality
- The expiratory wheeze is most commonly due to:
 - Bronchospasm
 - Mucus hypersecretion
 - Airway edema
 - Alteration of lung mechanics
- The mechanism of action of theophylline is associated with all but one of the following:
 - Increased cyclic AMP
 - Increased cyclic guanosine monophosphate (cyclic GMP)
 - Phosphodiesterase inhibition
 - An additive bronchodilator effect when used with beta agonists
- All but one of the following produces bronchodilation by increasing the intracellular level of cyclic AMP:
 - Theophylline
 - Epinephrine
 - Beclomethasone dipropionate
 - Isoetharine
- Forms of therapy that should be withheld at the onset of an asthma attack include:
 - Beclomethasone dipropionate
 - Cromolyn sodium
 - Prednisone
 - a and b

Last month's CME Quiz answers appear on Page 262

Answer sheet for Quiz: (Asthma in Children)

- | | |
|------------|-------------|
| 1. a b c d | 6. a b c d |
| 2. a b c d | 7. a b c d |
| 3. a b c d | 8. a b c d |
| 4. a b c d | 9. a b c d |
| 5. a b c d | 10. a b c d |

Name (please print or type)

Address

Identification number (found above your name on mailing label)

 Signature

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of THE JOURNAL for my information.

To be eligible for credit for this month's quiz, send your completed, signed application before May 10, 1980, to the address appearing at the top of this page.

NEWS NOTES

Here and There . . .

. . . **Dr. Jack H. Hall** of Indianapolis has been reappointed to serve a three-year term on the Indiana Medical Education Board. Also appointed to the board was **Dr. Robert P. Archer** of Greensburg.

. . . **Dr. Jerry L. Stucky** has been appointed director of family practice residency, Fort Wayne Medical Education Program. As such, he will coordinate residency training at the city's three community hospitals and at the Family Practice Center, Fort Wayne.

. . . **Dr. Steven C. Beering**, dean of the I.U. School of Medicine, has been named to the board of directors of the Indianapolis Center for Advanced Research.

. . . **Dr. Herman L. Hirsch** of Mount Vernon has been named associate medical director, Medical Department, Plastics Division, General Electric Company. His appointment is intended to provide direction for a fully operational medical facility at GE's Mount Vernon plant site.

. . . **Dr. Lowell H. Steen** of Hammond has been reappointed to the JCAH Board of Commissioners.

. . . **Dr. James E. Simmons** of Indianapolis has been appointed to the AMA Residency Review Committee for Psychiatry and Neurology.

. . . **Dr. Frederic L. Schoen** of Carmel has been appointed to the AMA Advisory Committee on Undergraduate Education.

. . . **Dr. Donald E. Wood** of Indianapolis has been reelected to a three-year term on the Board of Directors of the Indianapolis Chamber of Commerce.

. . . **Governor Otis R. Bowen, M.D.**, has been awarded the first "Hoosier Freedom Award" presented by the Indiana Trial Lawyers Association. It recognizes contributions to formulating and administering Indiana law.

. . . **Dr. Paul F. Muller**, medical director of St. Vincent Hospital, Indianapolis, has been elected president of Indiana Area V PSRO.

. . . Two more Indiana hospitals have been awarded two-year accreditation by the Joint Commission on Accreditation of Hospitals. They are **Methodist Hospital of Indiana, Inc.**, Indianapolis, and **Dearborn County Hospital**, Lawrenceburg.

. . . **Dr. Philip S. Zeitler**, chairman of the Department of Surgery at Elkhart General Hospital, has been appointed to a four-year term on the Elkhart City Plan Commission.

. . . **Dr. Rustico Dizon** has been elected chief of staff, Dearborn County Hospital, Lawrenceburg; **Dr. Harbans Gill**, chief of staff-elect; **Dr. Frederick Schnell**, secretary-treasurer.

. . . **Dr. Hansel O. Foley** has been elected president, Memorial Hospital, South Bend; **Dr. Philip R. Myers**, vice-president; **Dr. John O. Hildebrand**, secretary-treasurer.

. . . The newest members of the American College of Radiology are **Dr. Ada P. Harper** of Indianapolis, **Dr. John Lambertus** of Terre Haute, and **Dr. Sara E. Zieverink** of Indianapolis.

. . . **Dr. Michael R. Burt** of Indianapolis has been certified by the American Board of Neurological Surgery.

HELP FOR THE CONGENITALLY HANDICAPPED CHILD

It wasn't so long ago that congenitally handicapped children were allowed to reach school age or even later before being fitted with a prosthesis. In recent years, experience has shown that fitting at an earlier age produces more effective results—both mentally as well as physically. **HANGER** provides individually designed prostheses to give aid to the congenitally handicapped child. Children with "HANGER PROSTHESES" can live normal lives. Using their **HANGER** appliances they exercise freely, ride bicycles, roller skate, play basketball, tennis, and engage in most of the activities like other growing children. These activities enable the child to become self-reliant. Each **HANGER** prosthesis follows much the same design as those for the adult, but utilizes specially developed components of appropriate size, thus providing a smoother transition as the child grows into adulthood. **HANGER** also provides devices and techniques for the initial fitting of infants and problem cases. Training of children in the use of their prosthesis is highly desirable, even though children present some problems not seen in adults. Since the attention span of young children is short, extreme patience is required. Some handicaps make an ideal gait-pattern difficult if not virtually impossible to achieve. It should be noted that complete cooperation of the parent is necessary regardless of the experience and ability of the therapist. (Often the parents pass on a sense of guilt that is completely unfounded as there are no known preventive methods to combat the problem of a congenital handicap.)

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Indiana Medical Foundation

The Indiana Medical Foundation, Inc. was formed by the Indiana State Medical Association "for religious, charitable, scientific, literary or educational purposes." It provides financial assistance to support the educational mission of THE JOURNAL.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code. Gifts are deductible for Federal estate and gift tax purposes.

The Foundation is pleased to acknowledge the receipt of gifts in remembrance of the following individuals:

James A. Waggener
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Raymond Calvert, M.D.
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Mrs. Amelia Gosman
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John L. Arbogast, M.D.
Robert Dearmin, M.D.
Frank Harvey Cox
John P. Lordan, M.D.

Monographs From Sweden

The World Rehabilitation Fund conducts an International Exchange of Experts and Information. The Exchange announces availability of a monograph on *Readaptation After Myocardial Infarction* by Harald Sanne, M.D. of Goteborg, Sweden. Also available is a monograph on *Hospital-Based Community Support Services for Recovering Chronic Schizophrenics: The Experience at Lillhagen Hospital, Goteberg, Sweden* by Sven-Jonas Dencker, M.D. Copies may be obtained by writing to Diane Woods, 400 E. 34th St., New York, N.Y. 11016.

Home Health Care Guide

Physician's Guide to Home Health Care is now available for purchase from the AMA Order Dept., OP-077, P.O. Box 821, Monroe, Wisc. 53566.

The pamphlet, prepared by the AMA Council on Medical Service, cites the current emphasis on providing quality and less costly alternatives to institutional care as reasons for physician leadership in developing and providing home health care for patients who can benefit from such services.

Cost is \$1 each for 1-99 copies; 95¢ each for 100-499; 90¢ each for 500-999; and 85¢ each for 1,000 or more.

'The IPA Alternative'

The American Society of Internal Medicine has developed a new guide explaining the basics of individual practice associations (IPAs). The guide covers organizational structure, physician reimbursement, utilization and quality review and viability. In addition, the guide includes information on IPAs and federal qualification, and on further resources physicians can use to learn more about IPAs. Individual copies of the guide, *The IPA Alternative* are available for \$1.00 from ASIM, 2550 M Street, N.W., Suite 620, Washington, D.C. 20037.

Stroke Pamphlet Available

Stroke: New Approaches to Prevention and Treatment is the subject of Public Affairs Pamphlet No. 576. It is written by Arthur S. Freese, an accomplished medical science writer. He lists warning signs, discusses the connection of stroke and hypertension and arterial disease, and outlines treatment. He emphasizes alertness for warning signs and the importance of seeking medical advice as early as possible. The 20-page booklet sells for 50¢ per copy (quantity rates are available). Write Public Affairs Committee, 381 Park Avenue South, New York City 10016.

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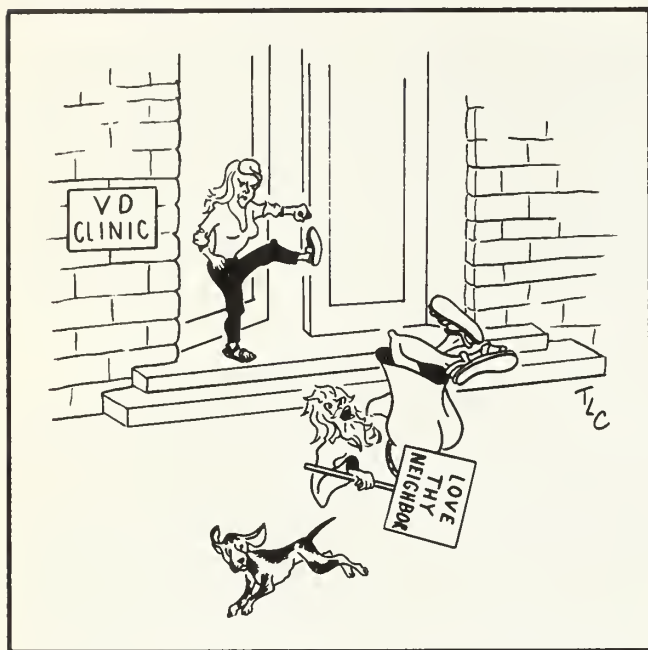
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NEWS NOTES



New Alcoholism Facility

The Koala Center of Lebanon announces HSA approval for construction of a 60-bed facility for the treatment of alcoholism in Columbus. Building will start later this year and should be completed by mid-1981. Services planned for the new facility will include detoxification and 30-day inpatient programs with one-year outpatient and aftercare programs. There also will be introductions to Alcoholics Anonymous and Alanon, recreational therapy, individual, family and group counseling, psychiatric evaluation, and psychological testing. The new service will be staffed by a 24-hour professional nursing contingent.

PMA, FDA Discuss

Newest Drug Regulations

Lewis A. Engman, new president of the Pharmaceutical Manufacturers Association, together with some top executives of the pharmaceutical industry, met recently with FDA personnel to discuss changes in regulations that govern the testing and certification of new drugs.

The FDA has composed a set of revisions to the regulations. The industry plans to submit detailed comments on these revisions and will offer changes in some regulations. Industry is also setting up a "new process for communications with scientists" involved in clinical research.

The PMA plan will concern an improved and differ-

ent method for dialogue with all scientists involved in new drug research with a view to determining in what areas the FDA should regulate clinical research, and to specify the criteria to be used by the Agency in ruling on the approvability of new drugs.

Engman says: "The PMA and its member companies are prepared to commit the industry's resources to working together with FDA in developing a mechanism toward this end."

Medical Hall of Fame

The All American Medical Hall of Fame of St. Louis is well along with its nomination and choosing processes in selecting three outstanding medical men from each state and also from each one of the medical specialties. The organizers are now seeking pictures of the nominees of a quality that would permit enlargement to 8x10 inches.

The nominees for Indiana are Drs. Harvey W. Wiley, John S. Billings, and Frank B. Wynn. Indiana is honored to have had two of the nominees who are to represent anesthesiology, Drs. Emery A. Rovenstine and Arthur Guedel, selected from Indiana University School of Medicine.

USP Dispensing Information

The United States Pharmacopeia Dispensing Information (USP DI) is now available. It is the first book to contain dispensing information for both the practitioner and the patient. The first section, for physicians, provides 364 general monographs with information on almost 1,200 drug substances and products. The second section is written in lay language. It has 213 monographs (42 are class monographs) representing 155 different drug substances. The index is by official names, categories of use and selected medical information. It includes cross-references by selected brand names and older non-proprietary names.

Information will be brought up to date bi-monthly. The updates are included in the publication price of \$18.75 per copy.

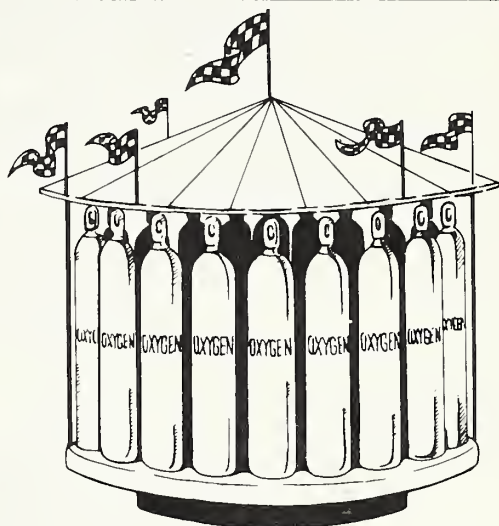
The USP Convention explains that the information "is designed for the dispensing situation and is not intended to provide 'full disclosure' prescribing information."

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NEWS NOTES

Greenberg Wins in Photo Contest

Stanley R. Greenberg, D.O., Garrett, received a certificate of merit in the 1979 Kodak International Newspaper Snapshot Awards sponsored by Eastman Kodak Company and conducted by 138 newspapers in the U.S., Mexico and Canada.

Dr. Greenberg is one of six physicians who received a Kodak Centennial Medallion for excellence in amateur photography as a part of Kodak's celebration of its 100th birthday.

Fellowships

American Academy of Orthopaedic Surgeons:

Dr. Alfred L. Bonjean, Merrillville;
Dr. Robert E. Colyer, Indianapolis;
Dr. Don R. Jardine, Indianapolis;
Dr. William E. Blair, LaPorte;
Dr. John L. Reynolds, Martinsville.

Indiana Historical Recordings

A project to record books and other materials on Indiana history was started in 1977 by the Indiana Historical Society. These recordings are for the blind and physically handicapped who was unable to read regular print books.

The program was initiated as a memorial to the late Eli Lilly who, in his later years, was a patron of the Division for the Blind and Physically Handicapped, Indiana State Library, where the recording studio for the project is located. The recordings are available to all eligible patrons of the Division.

For details, including volunteer opportunities, contact Indiana History Project Director, Indiana State Library, Division for the Blind and Physically Handicapped, 140 N. Senate, Indianapolis 46204. Tel: (317) 232-3682.

Physician Recognition Awards

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Alley, Thomas W., Indianapolis
Angel, Virgil E., Highland
Ash, Stephen R., Lafayette
Baran, Charles, South Bend
Barron, Elmer A., East Chicago
Bergwall, Warren L., Muncie
Berkson, Myron E., Michigan City
Bicalho, Jose F., Merrillville
Blix, Fred M., Indianapolis
Bombar, Leslie E., Munster
Borromeo, Venustiano H. J., Lowell
Brechtel, Harvey J., South Bend
Bretz, Robert D., Huntingburg
Buehl, Frederick H., Vincennes
Byllesby, Joyce E., Crawfordsville
Chang, Il W., Munster
Chivaprak, Charat, Crown Point
Clark, Eric D., Plainfield
Connelly, Richard D., Fort Wayne
Cortese, James V., Indianapolis
Daftary, Ali A., Batesville
Dainko, Alfred J., East Chicago
Davis, Edward A., South Bend
De La Flor, Eduardo P., Evansville
Deacon, Walter E., Indianapolis
Dew, Daniel C., Elkhart
Dietz, David J., Muncie
Duque, Fausto, Jeffersonville
Evans, Frederick H., Indianapolis
Evens, Marvin A., Indianapolis
Falcon, Nimitz P., Merrillville
Farag, Rafik S., Peru
Farquhar, John S., Evansville
Ferre, Harry L., Indianapolis
Ferry, John L., Hammond
Flannagan, Duane C., Jasper
Fosgate, Harold L., Indianapolis

Frankel, Gerald J., Indianapolis
Franz, Sherman G., Columbus
Garner, William S., Indianapolis
Gibson, Milton E., South Bend
Goldburg, Burt R., Marion
Gonzales, Seseando A., Highland
Good, Richard L., Munster
Goodell, Charles L., Muncie
Greenlee, Robert L., Fort Wayne
Guckien, Joseph L., Evansville
Hadidian, Henry A., Hammond
Haggerty, Fred E., Greencastle
Hamilton, Thomas G., Columbia City
Hammond, Stanley M., Munster
Henderson, Lawrence W., Vincennes
Hendrie, Hugh C., Indianapolis
Heritier, Claude J., Columbia City
Herring, Malcolm B., Indianapolis
Hodonos, Phillip E., Michigan City
Houck, Richard J., Beverly Shores
Huffman, Galen C., Fort Wayne
Hull, Ronald H., Indianapolis
Ireland, Philip H., Indianapolis
Keener, Gerald T., Indianapolis
Kelley, William E., Indianapolis
Koontz, James A., Vincennes
Kubley, James D., Plymouth
LaFollette, Forrest R., Hammond
Labitan, Cesar C., East Chicago
Leon, Mario, Jasper
Lourie, Bernard, Evansville
Lynn, Gene E., Indianapolis
Madura, James A., Indianapolis
Manifold, Harold M., Bloomington
Mann, Richard E., Fort Wayne
Martirez, Napoleon A., East Chicago
McClure, Warren N., Kokomo

Millan, Felix, Munster
Moeller, Victor C., Fort Wayne
Murillo, Herbert L., Munster
Nicosia, John B., East Chicago
Oei, Tijen O., Indianapolis
Pearce, Robert M., Indianapolis
Pohnert, William H., Kokomo
Reddy, Ramachandra K., Indianapolis
Rietman, H. Jerome, Evansville
Roeske, Nancy C., Indianapolis
Romain, Louis F., Fort Wayne
Rose, Robert E., Spencer
Sandock, Mark S., South Bend
Schaaf, Bernard J., Lafayette
Scheer, Alexander L., Elkhart
Sharville, Derek J., Lafayette
Shoemaker, Richard L., Lafayette
Shriner, Richard L., South Bend
Silbert, Robert K., Indianapolis
Smith, Jerald E., Munster
Smith, Robert D., Lafayette
Spurgeon, Charles H., Indianapolis
Stayton, Chester A., Beech Grove
Steele, Hugh H., Lafayette
Suwanwilai, Charoen, Griffith
Tadatada, Victoriano J., Salem
Townley, Normand T., Indianapolis
Trier, Herbert P., Fort Wayne
Urba, Vytautas V., Munster
Van Den Bosch, Wallace R., Lafayette
Vogel, Lawrence J., Mount Vernon
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OBITUARIES

Willard T. Barnhart, M.D.

Dr. Barnhart, 71, an Evansville urologist, died Feb. 7 at Deaconess Hospital, Evansville.

He received his M.D. degree in 1933 from Washington University, St. Louis. He practiced in St. Louis until World War II, when he served in the Army-Air Force.

Dr. Barnhart was a former president of the Vanderburgh County Medical Society and a past president of the Deaconess Hospital medical staff. He was a fellow of the American College of Surgeons and a diplomate of the American Board of Urology.

Jack A. Bush, M.D.

Dr. Bush, 52, a Lafayette anesthesiologist, died Feb. 4 as the result of a fire in his W. Lafayette home.

He was a 1953 graduate of the Indiana University School of Medicine.

Dr. Bush had been a general practitioner in Lafayette until 1960 when he returned to I.U. for training in anesthesiology. He had served in the Navy from 1956-58.

Orley E. Wilson, M.D.

Dr. Wilson, 76, a retired Elkhart physician, died Feb. 24 at his home.

He received his M.D. degree in 1931 from Northwestern University. He retired in 1972.

Dr. Wilson had served for several years as secretary-treasurer of ISMA's 13th Medical District.

Clarence B. LaDine, M.D.

Dr. LaDine, 75, a retired Indianapolis physician, died Feb. 7 in his home.

He was a 1939 graduate of the Indiana University School of Medicine and was an Army veteran of World War II.

Dr. LaDine became a senior member of the Indiana State Medical Association in 1976.

Clarence R. McIntire, M.D.

Dr. McIntire, 58, head of the radiology department at Bloomington Hospital, died Feb. 20 at the hospital.

He was a 1946 graduate of the Indiana University School of Medicine.

Dr. McIntire, a diplomate of the American Board of Radiology, was a member of the American College of Radiology and the Radiological Society of North America.

Casmiro P. Navarro, M.D.

Dr. Navarro, 56, a rating specialist who worked 11 years with the Veterans Administration in Indianapolis, died Feb. 19 in Winona Memorial Hospital.

He was a 1950 graduate of Manila Central University's College of Medicine. He served in the Philippine Army during World War II and was a member of the Philippine Medical Association.

Richard K. Schmitt, M.D.

Dr. Schmitt, 79, a retired Columbus physician, died Feb. 7 at Bartholomew County Hospital.

He earned his M.D. degree in 1931 from Rush Medical College, Chicago. He served with the Army in the Pacific during World War II.

Dr. Schmitt, a senior member of the Indiana State Medical Association since 1971, recently had been reappointed to the Bartholomew County Hospital Honorary Medical Staff.

Eldore M. Hoetzer, M.D.

Dr. Hoetzer, 66, a New Haven physician since 1946, died Feb. 8 at Parkview Memorial Hospital, Fort Wayne.

He was a 1940 graduate of the Indiana University School of Medicine and was a World War II veteran.

Dr. Hoetzer was a past president of the Parkview Memorial Hospital medical staff and was a member of the American Academy of Family Physicians.

March 1980 CME Quiz Answers

Answers to the CME quiz that appeared in the March 1980 issue of THE JOURNAL: "Initial Care of the Burned Patient," by Lewis R. Kinkead, M.D.:

- | | |
|----------|----------|
| 1. b | 6. True |
| 2. e | 7. False |
| 3. True | 8. True |
| 4. False | 9. True |
| 5. False | 10. True |

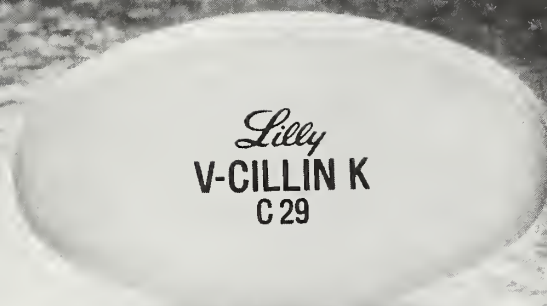
Answers to the Sandoz Prize CME quiz that appeared in the March 1980 issue of THE JOURNAL: "Sideroblastic Anemia: Evaluation and Prognosis," by Mark W. Braun, M.D.:

- | | |
|------|-----------|
| 1. c | 6. False |
| 2. b | 7. True |
| 3. b | 8. True |
| 4. c | 9. False |
| 5. d | 10. False |

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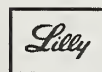
Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiopasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

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INTERNIST-TAMPA BAY AREA-FLORIDA—Prepaid Health Care, Inc., a federally qualified HMO, is recruiting internists, BE or BC, for adult ambulatory care units in Clearwater and St. Petersburg. Excellent salary and benefit programs, with opportunity to participate in academic program available. Progressive, growing community. If interested in growing with us, send CV to Jerry Williamson, M.D., Medical Director, 1417 S. Belcher Road, Clearwater, Florida 33516. Tel: (813) 535-3474.

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NEEDED: Staff physician, general practice. Must be medical school graduate and eligible for Indiana license. \$45,000 annual guarantee plus private office (furnished), 40 hours minimum (to vary) per week. Contact Andrew J. Barrett, II, Executive Director, Adams County Memorial Hospital, 805 High St., Decatur, Ind. 46733. Tel: (219) 724-2145.

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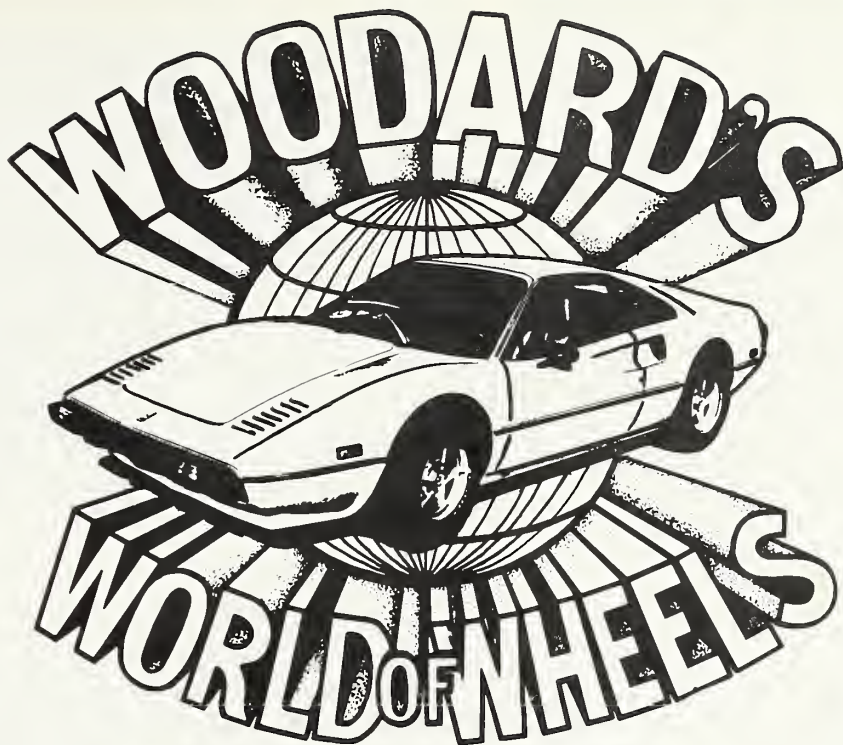
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FUTURE FILE

CONTINUED FROM PAGE 217

Nuclear Cardiology

"Nuclear Cardiology for the Practicing Physician" (The Third Annual Symposium) will be conducted at the Hilton Head Inn, Hilton Head Island, South Carolina, July 27 to 30. Rated for 20 hours Category I credit. Registration deadline is April 15. Contact Jagmeet S. Soin, M.D., 8700 W. Wisconsin Ave., Milwaukee 53226. Tel: (414) 257-5968.

I.V. Nurse Convention

The National Intravenous Therapy Association will conduct its Eighth National Convention at the Marriott Hotel in Atlanta May 4 to 8. Membership of the organization is composed principally of registered nurses active in the field of intravenous therapy. Exhibitors will display the latest I.V. equipment.

Audiology Courses in Ohio

Ohio State University's Department of Otolaryngology will conduct a refresher course May 13 for occupational hearing conservationists; the course meets recertification requirements for those with CAOHC certification.

The Department will conduct a training course for audiometric technicians May 14-16; accredited by CAOHC, its successful completion provides qualification for certification.

For information on both courses, contact Ernest R. Nilo, Ph.D., Audiology Section, University Hospitals Clinic, Rm. 4024, 456 Clinic Dr., Columbus, Ohio 43210. Tel: (614) 422-4004.

Blood Banking Conference

"The Management and Logistics of Blood Banking" will be the subject of the 1980 conference sponsored by the American Blood Commission and the National Heart, Lung and Blood Institute at the Regency Hotel, Denver, Colo., June 2-3. The meeting is open to all those interested and concerned with ways to improve management of blood resources.

Primary Care Patient Education

The Fourth National Conference on Patient Education in the Primary Care Setting will be held May 21-23 at the Hyatt Regency Hotel, Memphis, Tenn.

Full information is available from Donna Miller, Ph.D., 66 N. Pauline, Suite 233, Memphis 38105.

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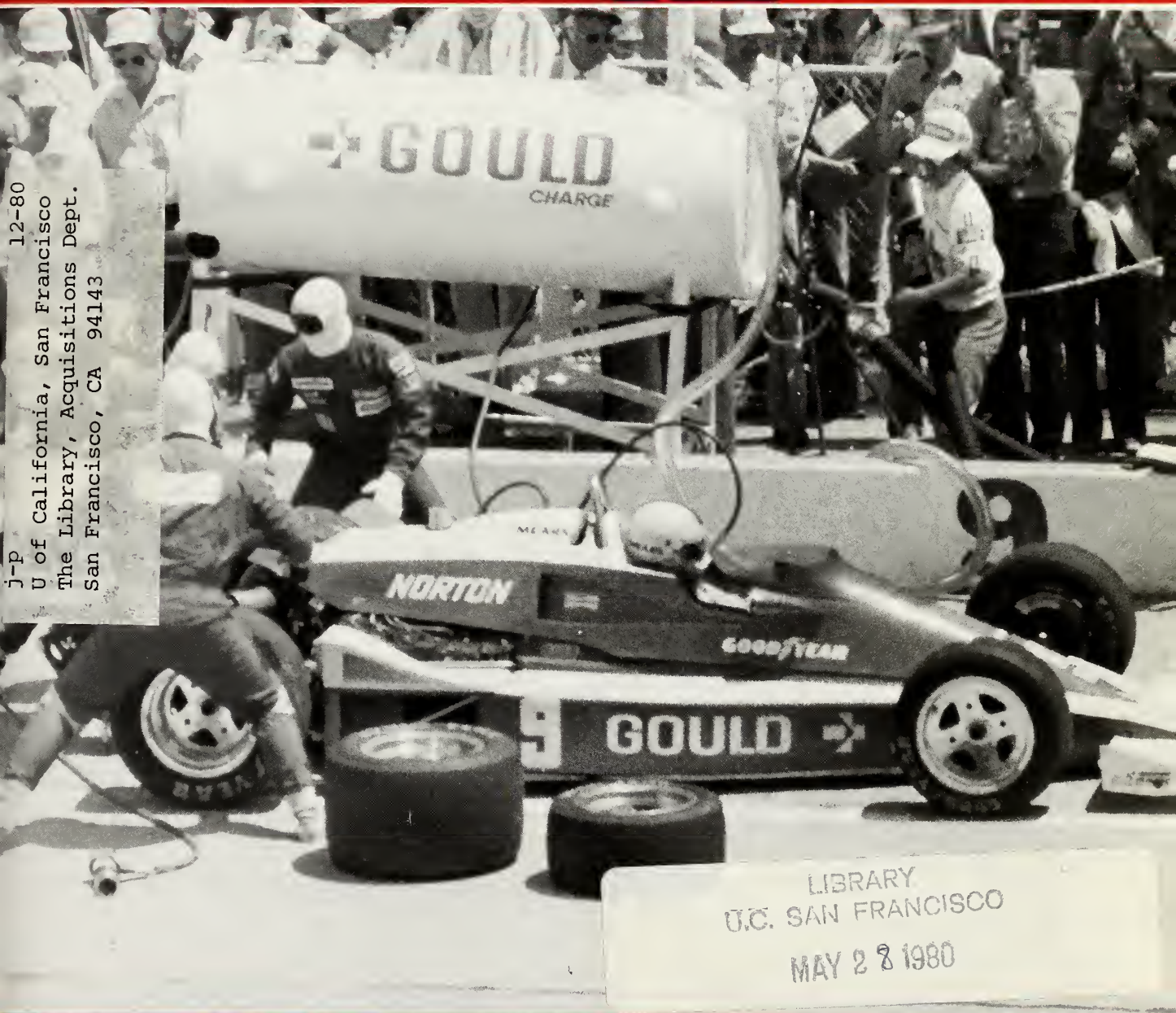
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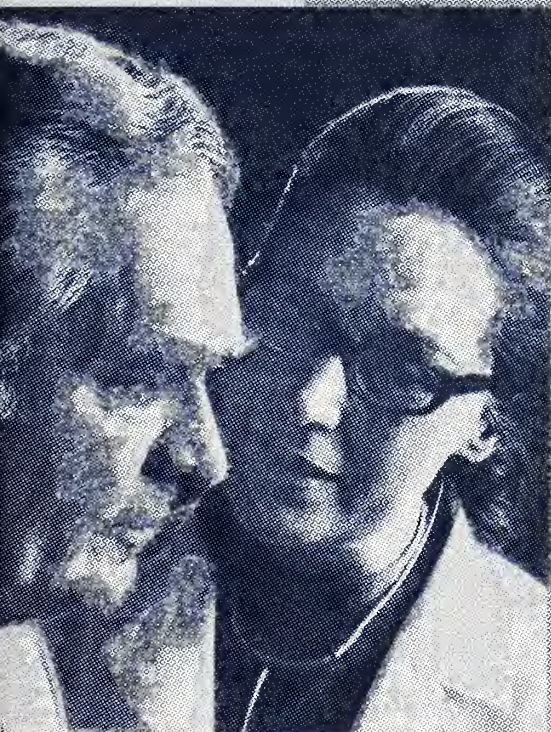
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Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

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ORTHO PHARMACEUTICAL has introduced INTERCEPT[™] Contraceptive Inserts. The new preparation is a vaginal contraceptive suppository containing a high concentration—100 mg—of the potent sperm-killing agent, Nonoxynol-9. The incidence of possible irritation is reduced with INTERCEPT as a result of its gentle foaming agent.

THE RELIEF OF MINOR ITCHING caused by contact dermatitis, insect bites and heat rash is now possible with the use of Topic[®], a preparation offered by Syntex. Topic is 5% benzyl alcohol in a soothing gel base containing camphor, menthol, 20% isopropyl alcohol, water, hectorite, propylene glycol, sodium laureth sulfate, perfume and color. The gel base is greaseless, non-occlusive and water-washable.

WALLACE LABORATORIES announces FDA approval for "THYRO-BLOCK" in both tablet and solution form of Potassium Iodide for use in radiation emergencies only. Approval for this use does not affect status of KI products prescribed for other purposes.

ABBOTT LABORATORIES announce a new test for identifying patients at risk of thrombosis. Quanti-chrom[®] AT III measures levels of antithrombin III. Depression of the AT III level can indicate increased risk of clot formation. The test is useful in surgical patients, candidates for heparin therapy, women on oral contraceptives, patients with a history of thrombotic diseases, and persons with a hereditary deficiency of AT III.

CONTINUED ON PAGE 340

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

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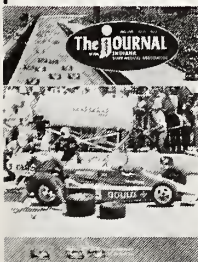
Publication deadline: 1st day of month preceding month of issue.

Subscriptions: \$14 per year, USA; \$16, Canada; \$17, foreign; \$12, libraries; \$10, senior ISMA members; \$8, members; except for special issues, single copies not available. Subscriptions renewable only in January and July.

Second-class postage paid at Indianapolis, Ind. and additional mailing office.

ABOUT THE COVER

Rick Mears, winner of last year's 500-Mile Race at the Indianapolis Motor Speedway, averaged 158.899 MPH. Pit stops are necessary for refueling and changing tires—but another, perhaps lesser known, “pit stop” is the track hospital, which stands ready to provide medical care for drivers and spectators alike. See Page 288.



MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

THE TECHNICAL QUALITY of the photograph reproduced here leaves much to be desired, but a poor photograph is better than no photograph at all. This copy, from a newspaper, is the only photograph we have of Dr. Mary Frame Thomas, the first woman to be admitted to the Indiana State Medical Society, and the second to be admitted to the AMA.

Mary Frame Thomas, nee Myers, was born Oct. 28, 1816 near Washington, D.C., of Quaker parents. Her early education was provided by her father, who was a farmer. The family moved to Ohio, where Mary met and married Dr. Owen Thomas (in 1833, at the age of 17 years), who then became her preceptor in medicine. The marriage was a long happy one, producing three daughters, among other achievements.

Mary Thomas was described as a model wife and mother. She not only attended to the usual household chores, at a time when there were no labor-saving devices, she also made all of her children's clothing by hand; and she not only found time to study and practice medicine, she also found time to participate in numerous other activities, and was able to achieve all this, as she stated, "by the most vigorous discipline of my mind . . . and systematic arrangement of (my) time. . ."

Dr. Thomas was an active abolitionist, and also a leader in the Women's Rights Movement of the mid-19th Century. Newspapers of that period read very much like the papers of today, in terms of demands for equal rights, equal pay, and equal opportunities. These demands also applied to equal education opportunities, including admission to the medical schools—a concept whose popularity was largely confined to the female sex, and not to all of them.



Mary Frame Thomas, M.D.
(1816-1888)

Dr. Thomas attended the Female Medical College in Philadelphia for the 1851-1852 session. She then attended a session of lectures at the Cleveland Medical College, and then returned to Philadelphia to the Penn Medical University for Women, where she received the M.D. degree in 1854. She was 38 years old at this time. (The *INDIANAPOLIS LOCOMOTIVE*, a weekly newspaper published from 1848 to 1860, reported this event on page 2 of the July 21, 1855 issue. This same article indicated that a second Indiana woman, Mary A. Holloway of Crawfordsville, was also enrolled in the medical school. If she, too, practiced in Indiana, we have found no record. Perhaps someone from Crawfordsville will recognize the name.)

Mary and her husband settled in Fort Wayne to practice together.

She tried twice to join the Allen County Medical Society, but was refused admission because of her sex. The Thomas' then moved to Richmond, Ind. In 1875 she was admitted to the Wayne County Medical Society, and in 1876 was admitted to the Indiana State Medical Society.

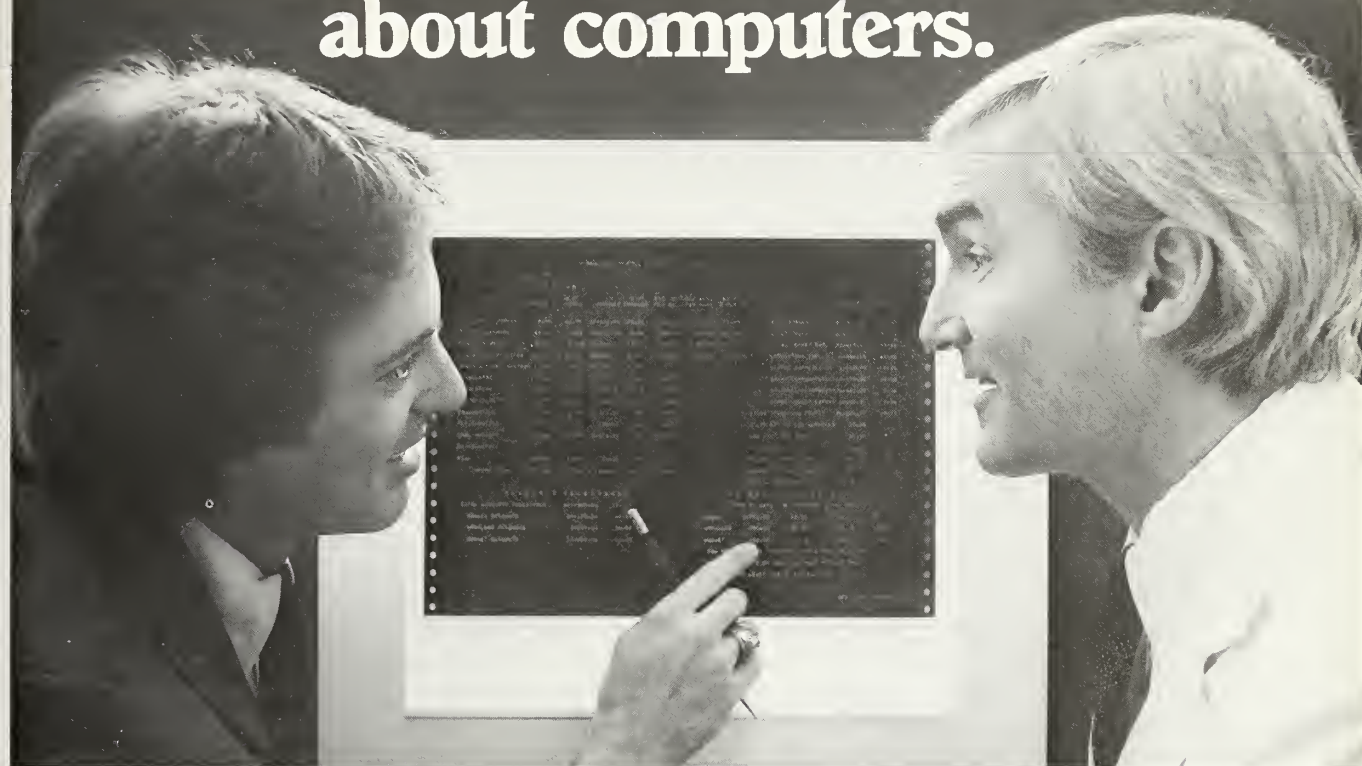
Dr. Thomas was editor and publisher of *THE LILLY*, a paper devoted to women's rights. She worked to establish a separate prison for women, and a separate reformatory for girls. She headed a group that petitioned the State Legislature to grant women the same property rights as men, and to amend the Constitution so as to permit women suffrage. (The legislature did neither.)

How did she get along with her medical colleagues throughout the state? She was well liked by all, and revered by some. Kamper describes her as ". . . a faithful worker in everything that aimed to make the human race better."

Dr. Mary Thomas was 60 years old when she was admitted to the Indiana State Medical Society. She was nearly 72 when she died, Aug. 19, 1888.

Biographical material for this column came from the columns of the Richmond, Indiana *EVENING ITEM*, and *TELEGRAM* (Aug. 22, 1888). A reprint of one of Dr. Thomas' contributions to the *TRANSACTIONS OF THE INDIANA STATE MEDICAL SOCIETY* was reproduced in the No. 3, 1979 issue of the *INDIANA MEDICAL HISTORY QUARTERLY*. Dr. Thomas attended the first session of lectures at the Indiana Medical College, when that school opened its doors in 1869, and was harassed by some of the male members. She recalls this experience in the article, and takes the opportunity to urge Indiana physicians to be more broadminded with regard to the female physician.

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EDITORIALS

Pepper Joins Cancer List; Generic Regs Need Change

There is a growing suspicion, on the part of many, that everything is carcinogenic. The latest on the list is pepper.

Robert C. Barnard of the American Industrial Health Council recently addressed the New York Academy of Sciences with advice that regulations should be changed and that a more precise rating system be established for classifying and reporting results of research on carcinogens.

There is a world of difference between real carcinogens and the multitude of chemicals which will give a carcinogenic "signal" in some test system, at some dose.

Regulations treat the members of each classification the same. Since the list of substances which give a carcinogenic "signal" is enlarged each year by a few hundred entries, a more realistic approach is mandatory. Part of the increase is due to development of new and more sensitive analytical methods.

A recent FDA warning contained this: "Indeed, a requirement for a warning on all foods that contain an inherent carcinogenic ingredient or a carcinogen contaminant (in contrast to a deliberately added carcinogenic substance) would apply to many, perhaps most, foods in the supermarket." (44 Fed. Reg. 59513)

Mr. Barnard urged regulatory agencies to rethink their strategy on generic regulations. He emphasized that the increase in carcinogenic "signals" is due to better measurement technology. There is no increase in cancer incidence. Men had a slight increase since 1937 due to lung cancer. Rates have decreased in women.

Present generic regulations treat all substances identified as carcinogens as equally toxic. It is time to change the regulations. The thousands of carcinogenic "signals" should be differentiated from the real hazards.

Encephalitis Survey Results

Antibody study of the blood of 10,200 Hoosiers by Notre Dame's Vector Biology Laboratories for the Indiana State Board of Health is interpreted as an indication that more than 300,000 of Indiana's 5.3 million residents have had mosquito-borne encephalitis virus infections. Of 367 blood samples with antibodies to St. Louis encephalitis, only one had been previously diagnosed. The incidence of LaCrosse encephalitis is less, with an estimated 120,000 cases. The survey is of clinical interest because the effects on the central nervous system are sometimes not evident for several years.

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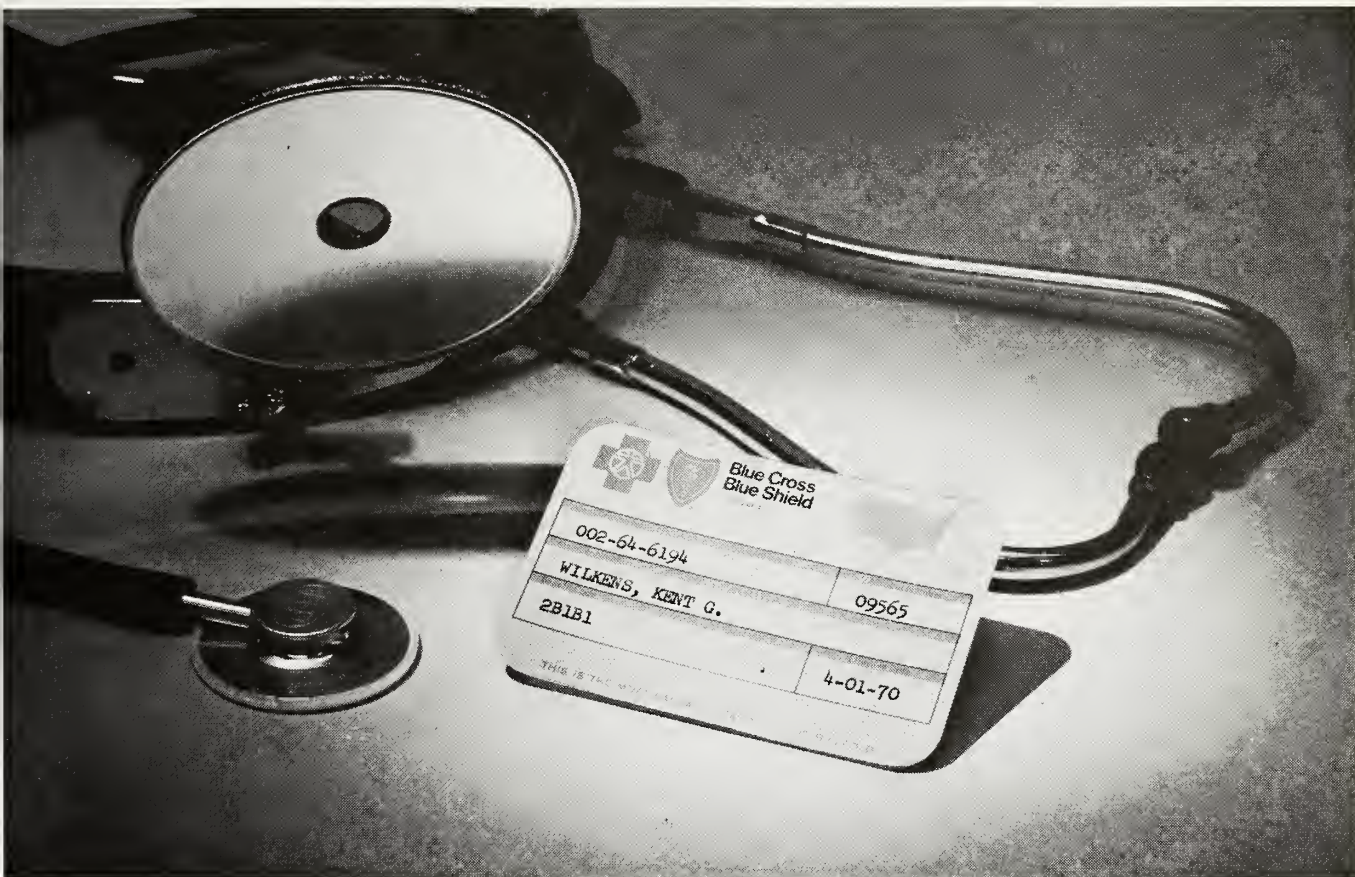
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7—Jahn G. Pantzer, Indianapolis	Oct. 1981
8—Jack M. Walker, Muncie	Oct. 1981
9—John A. Knot, Lafayette (Chairman)	Oct. 1982
10—Martin J. O'Neill, Valparaisa	Oct. 1980
11—Herbert C. Khalouf, Marion	Oct. 1981
12—DeWayne L. Hull, Fort Wayne	Oct. 1982
13—Donald S. Chamberlain, South Bend	Oct. 1980

ALTERNATES

District	Term Expires
1—E. DeVerre Gaurieux, Evansville	Oct. 1982
2—Edgar R. Cantwell, Vincennes	Oct. 1980
3—Eli Hallal, New Albany	Oct. 1980
4—Mark M. Bevers, Seymour	Oct. 1982
5—Benny Ko, Terre Haute	Oct. 1982
6—Dan W. Hibner, Richmond	Oct. 1981
7—Jahn D. MacDaugall, Beech Grove	Oct. 1982
7—H. Marshall Trusler, Indianapolis	Oct. 1982
8—Richard L. Reedy, Yarktown	Oct. 1982
9—Max N. Haffman, Cavington	Oct. 1980
10—Leonard W. Neal, Munster	Oct. 1982
11—Fred C. Poehler, La Fontaine	Oct. 1980
12—Franklin A. Bryan, Fort Wayne	Oct. 1980
13—Jahn W. Luce, Michigan City	Oct. 1982

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Blue Shield**
of Indiana

Experts Seek Ways to Spur Pharmaceutical Research

Almost all the research and development (R&D) of new drug entities in the U.S. is conducted by the research-oriented pharmaceutical firms.

At a recent meeting of "Foresight Seminar," a background session sponsored by Hoffmann-LaRoche for Capitol Hill staffers, the subject was the decreasing supply of R&D money.

R&D costs are up each year by about 17%, while sales that produce the money are up by less than 10%. Also, the time required for market approval of new drugs is lengthening. This reduces the patent life of the drug and the time in which a portion of the R&D cost can be recovered by its discoverer.

Estimates for the cost of discovery and development of a new entity were once quoted as between \$5 million and \$15 million. Today \$15 million is the minimal figure and up to \$50 million is the maximum. No wonder the U.S. discovery rate is diminishing.

Both FDA and industry officials at the "Foresight Seminar" discussed the dilemma at length and suggested changes in the drug approval system and in patent protection. Some changes must be made else the new drug discovery program will dry up completely.

FDA Actions: The Physician's View

The AMA and the FDA conferred recently on the subject of current drug problems. Views of physician-consumers were presented by AMA officials to FDA Commissioner Jere Goyan and top agency officials on recent FDA actions.

The *Newsletter* of the Pharmaceutical Manufacturers Association reports that the AMA comment concerning patient package inserts for all prescription drugs was: "These will sharply circumscribe indications, routes, and dosages, thus further limiting the ability of physicians to tailor therapy to the needs of individual patients."

In regard to proposed revision of amphetamine labeling: "No evidence is available to controvert the safety and efficacy of these drugs as short-term adjuncts in obesity management."

The AMA opinion on the possible removal of propoxyphene from the market is: "There is a lack of evidence to show it is unsafe or that it causes abuse liability when taken as directed."

On the subject of withdrawal of *Erythromycin estolate* on ground of hepatotoxicity, the AMA statement is: "The incidence of this side effect is exceedingly low (less than 1:128,000); the reaction is reversible and nonfatal; and the estolate ester is better-tasting and better absorbed in a nonfasting state than other forms of erythromycin."

Regarding the proposed labeling of oral hypoglycemic drugs as causing "an excess number" of cardiovascular deaths, the opinion is: "It ignores a substantial body of evidence controverting this controversial UGDP allegation and, for all intents and purposes, mandates insulin for treatment of almost all patients with adult-onset, nonlabile diabetes."

In summary, the AMA group reminded Dr. Goyan as follows: "FDA has a Congressional mandate to ensure that approved drugs are safe and effective. It has no mandate to decide how many drugs of a class should be available or to dictate how physicians will use them."

Additional AMA recommendations were for amendments to speed new drug approval, to improve communications between FDA and medical practitioners, and to counter-balance the predominance of academicians on FDA advisory panels by including more practicing physicians.

Bill Seeks to Lower Costs By Increasing Competition

A bill, proposed by Senator David Durenberger, (R-Minn.) seeks to reduce the rate of increase in medical-care spending by increasing competition and consumer choice.

In testimony before Congress, Karl Bays, chairman of American Hospital Supply Corp., emphasizes that, while the bill offers tax incentives to encourage employers to offer cost-effective medical insurance and prepaid health-care programs to their employees, the proposed system must avoid regulation by government and must truly promote competition.

Bays points out that there should be the broadest possible variety of delivery options and one form of health-care delivery should not be favored over another. He said teaching hospitals must be protected so as not to interfere with research and teaching functions. And he thinks that the bill should extend the requirements to Medicare and Medicaid programs.

All of which reminds us that medical care is a complicated procedure that works best as a free enterprise. When it has faults, legislation is the worst form of remedy.

Persantine-Aspirin Reinfarction Study

A five-year study on the effect of the combined use of Persantine and aspirin as a preventive of secondary coronary occlusion indicates that the drug combination reduced coronary incidence significantly and consistently over 24 months. Controls used were aspirin alone and a placebo. Aspirin was inconsistent. Further studies are being conducted with a view of obtaining FDA approval.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®]™

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache. Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e. more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlordi-

azepoxide, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery. Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Metrazol, or am-

phetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug.

Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdose with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

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Philadelphia, Pa 19101



FOR MODERATE PAIN

A therapeutic dose of acetaminophen in one tablet

A therapeutic dose of two complementary analgesics

The convenience and economy of a dosage schedule of one tablet, every four hours as needed



WHY NOT WYGESIC[®] IV

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.

CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdose).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.

USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down. Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended (see Warnings). Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSEAGE: SYMPTOMS: The manifestations of serious overdose with propoxyphene are similar to those of narcotic overdose and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdose with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill; however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, naltrexone, and levorphanol, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analgesic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdose (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Wyeth Laboratories
Philadelphia, Pa. 19101



EDITORIALS

Lilly's Darvon Information Program

Eli Lilly & Company, following FDA advice in 1979 concerning an informational program in regard to the proper clinical use of propoxyphene (Darvon and Darvon-N), has participated in an extensive educational effort to this effect.

Personal contact by Lilly representatives, letters to physicians, patient information sheets to accompany prescriptions for the drug, pharmacy prescription vial stickers and journal advertisements have all been utilized. All of the serious side effects attributed to propoxyphene in the past have been connected with its use in an improper way.

Incidents of untoward reaction to the proper use of propoxyphene have been nil or extremely rare. Eli Lilly & Company is now presenting data to the FDA to illustrate the extent of the information program and its demonstrated effect.

The incidence of propoxyphene mentions in medical examiner reports is taken as an indicator of the improper use of the drug. A graph of these indicators shows a considerable incidence from 1974 to 1977. At that time, due evidently to influences aside from the Lilly educational program, the incidence curve descended to

its lowest point since 1974. However, in 1979 the Lilly program demonstrated its efficacy by producing an even steeper decline to almost zero.

The FDA is critical of the results despite the demonstration of the obvious fact that propoxyphene, when used clinically in the approved manner, is safe and efficacious.

Prescription Drug Prices Below 1979 Inflation Rate

Prices at the retail level for prescription drugs have risen at a slower rate than prices of all commodities for many, many years. In fact, for the last five years all commodities have had an annual rate of rise 28% higher than prescription drugs. The index for prescription drugs in 1979 was up by 7.7%; all commodities were up by 13.3%. And, good news for all medical service people, medical care prices went up by only 10.4% last year. The measuring scale for each item and for all conglomerate items started at 100 in 1967. In 1979 the all commodities index was 235.4, while the prescription drug index stood at 141.2.



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Shin splints, sore knees, exhaustion... you simply don't need it. What you do need is the absolutely predictable results you get from exercising on a Dynavit.

Dynavit is the world's first exercise computer with a computer control system. And here's the best part: you don't have to be an athlete; only 20-25% of your muscular strength is needed!

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Let's face it. When you do other kinds of exercise, chances are, you don't really know how much is enough or even if you're getting any benefit from it. But,

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So, if you're looking for the best way to tone your cardiovascular system, handle stress and take off some pounds without wrecking your body, mail-in the coupon now, or call toll free: 1-800-323-1475 (in Illinois, call collect, 312-272-6417).





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JID-3 0202

Drug Lag Exists: Blames Economic Costs, Regulatory Burdens

Commentary

REP. JAMES H. SCHEUER (D-N.Y.)

Following are highlights of an address by The Honorable James H. Scheuer, presented to the Preventive Medicine Foundation earlier this year. He is chairman of the House Commerce Consumer Protection and Finance Subcommittee.

"The evidence presented by the GAO and other subcommittee witnesses convinced me, without a doubt, that a drug lag does, in fact, exist and that it is significant. It is also evident that the substantial delays—seven to 10 years—and the exorbitant cost—up to \$50 million—of getting a new drug approved in this country have produced no net benefits to the American consumer in terms of safer or more effective drugs. On the contrary, some American patients have paid a high price in terms of the unavailability of one of the most cost-effective methods of health care: drug therapy. . .

"Between July 1975 and February 1978, the FDA approved 14 drugs it classified as important. Thirteen of these drugs were available in other industrialized countries anywhere from two months to 12 years before they were approved in the United States . . .

"There are even examples of therapeutically important drugs that were actually developed by U.S. firms, yet the U.S. was anywhere from the 15th to the 40th country to approve them for marketing . . .

"The evidence of declining American innovation in the pharmaceutical field is equally alarming. A recent study shows that between 1971 and 1973 only 39% of the basic new drug entities marketed in the U.S. originated with American firms, compared with 70% during the previous three decades. An increasing tendency of American companies to do their research abroad is reflected in the fact that only nine of the 56 new drug entities introduced worldwide in 1977 were developed in the United States . . .

"Our patent system, designed to spur technological progress, has been rendered ineffective by regulation. It is now frequently impossible to get the reasonable return on research investment that makes the whole process worthwhile. This phenomenon should be particularly alarming to all of us because the ultimate losers are individual American patients in need of drug therapy . . .

"It is my fear that we have created an economic and regulatory environment in this country which penalizes innovation and stifles productivity. Our regulatory agencies, originally established to protect the American consumer, have frequently become the enemies of progress, and it is the consumer who has paid the price. We are losing the fruits of research and development by small firms and individual scientists and chemists because they can no longer bear the economic costs or regulatory burdens of innovation . . ."

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All we want you to do is tell eligible students about us. Have them contact: Student Services, RFB, Inc., 215 East 58th Street, N.Y., N.Y. 10022, (212) 751-0860. We'll take it from there.

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an educational lifeline.

When systemic antifungal therapy must be instituted
even in compromised patients...

lack of nephrotoxicity makes Monistat i.v. the therapy of choice


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With MONISTAT^{*} i.v. you can:


- **Start treatment early**
...without fear of kidney damage.
- **Continue treatment as long as necessary**
No renal damage has been reported in long-term use.
- **Treat again and again if needed**
No renal toxicity has been reported even in patients
receiving several courses of therapy.
- **Treat patients with pre-existing renal failure**
MONISTAT^{*} i.v. has not been reported to cause
further renal damage.



Candida albicans



Coccidioides immitis



Paracoccidioides brasiliensis



Cryptococcus neoformans

Highly effective, improvement often seen within 1-3 weeks

Patients who do not respond or develop resistance to amphotericin B have responded to MONISTAT[®] i.v.

Resistance does not develop

In vitro resistance of clinical isolates has not been reported during clinical trials.

Generally well tolerated by severely debilitated patients

Patients with cancer, those receiving immunosuppressive agents, and patients with serious underlying conditions, such as diabetes mellitus or renal failure.

Photos courtesy of Dubos, R.J., Bacterial and Mycotic Infections of Man, J.B. Lippincott Company, 1965 and Burrows, W., Textbook of Microbiology, W.B. Saunders Company, 19th edition.

Please turn page for Prescribing Information.

An important advance in the treatment of systemic mycoses

Monistat i.v.

(miconazole)

TRADEMARK

broad-spectrum antifungal agent



JANSSEN PHARMACEUTICA INC.
New Brunswick, N.J. 08903

Committed to research...
because so much remains to be done

Broad-spectrum antifungal agent

Monistat i.v.

(miconazole)

for intravenous infusion



DESCRIPTION: MONISTAT i.v. (miconazole), 1-[2-(2,4-dichlorophenyl)-2-[(2,4-dichlorophenyl) methoxy] ethyl]-1H-imidazole, is a synthetic antifungal supplied as a sterile solution for intravenous infusion. Each ml of this solution contains 10 mg of miconazole with 0.115 ml PEG 40 castor oil, 1.0 mg lactic acid USP, 0.5 mg methylparaben USP, 0.05 mg propylparaben USP in water for injection. Miconazole i.v. is a clear colorless to slightly yellow solution having a pH of 3.7 to 5.7.

CLINICAL PHARMACOLOGY: MONISTAT i.v. is rapidly metabolized in the liver and about 14% to 22% of the administered dose is excreted in the urine, mainly as inactive metabolites. The pharmacokinetic profile fits a three-compartment open model with the following biologic half-life: 0.4, 2.1, and 24.1 hours for each phase respectively. The pharmacokinetic profile of MONISTAT i.v. is unaltered in patients with renal insufficiency, including those patients on hemodialysis. The in-vitro antifungal activity of MONISTAT i.v. is very broad. Clinical efficacy has been demonstrated in patients with the following species of fungi: *Coccidioides immitis*, *Candida albicans*, *Cryptococcus neoformans*, and *Paracoccidioides brasiliensis*.

Recommended doses of MONISTAT i.v. produce serum concentrations of drug which exceed the in-vitro MIC values for the fungal species noted above. Doses above 9 mg/kg of MONISTAT i.v. produce peak blood levels above 1 µg/ml in most cases. The drug penetrates into joints.

INDICATIONS: MONISTAT i.v. is indicated for the treatment of the following severe systemic fungal infections: coccidioidomycosis, candidiasis, cryptococcosis, paracoccidioidomycosis, and for the treatment of chronic mucocutaneous candidiasis. However, in the treatment of fungal meningitis and urinary bladder infections an intravenous infusion alone is inadequate. It must be supplemented with intrathecal administration and bladder irrigation. Appropriate diagnostic procedures should be followed and MIC's should be determined.

MONISTAT i.v. should not be used to treat common trivial forms of fungal diseases.

CONTRAINDICATIONS: MONISTAT i.v. is contraindicated in those patients who have shown hypersensitivity to it.

WARNINGS: Rapid injection of undiluted MONISTAT i.v. may produce transient tachycardia or arrhythmia.

PRECAUTIONS: Before a treatment course of MONISTAT i.v. is started, the physician should make sure that the patient is not hypersensitive to the drug product. MONISTAT i.v. should be given by intravenous infusion. The treatment should be started under stringent conditions of hospitalization but subsequently may be given to suitable patients under ambulatory conditions with close clinical monitoring. It is recommended that an initial dose of 200 mg be given with the physician in attendance. It is also recommended that clinical laboratory monitoring including hemoglobin, hematocrit, electrolytes and lipids be performed.

It should be borne in mind that systemic fungal mycoses may be complications of chronic underlying conditions which in themselves may require appropriate measures.

JANSSEN PHARMACEUTICA INC.

501 George Street
New Brunswick, N.J. 08903

Attn: D.T. Mallegol

Please send me more information about the use of
MONISTAT i.v.TM (miconazole) in systemic candidiasis
and other systemic mycoses.

M.D.

Address _____

City _____ State _____ Zip _____

Specialty _____

May, 1980

Pregnancy: Reproductive studies with MONISTAT i.v. in rats and rabbits revealed no evidence of impaired fertility or harm to the fetus. There are no data, however, on the use of the drug in pregnant women.

Children: Since the safety of miconazole i.v. in children under one year of age has not been extensively studied, its benefits in this age group must be weighed against the possible risks involved.

ADVERSE REACTIONS: Adverse reactions which have been observed with MONISTAT i.v. therapy include phlebitis, pruritus, rash, nausea, vomiting, febrile reactions, drowsiness, diarrhea, anorexia and flushes. In the U.S. studies, 29% of 209 patients studied had phlebitis, 21% pruritus, 18% nausea, 10% fever and chills, 9% rash, and 7% emesis. Transient decreases in hematocrit and serum sodium values have been observed following infusion of MONISTAT i.v. Thrombocytopenia has also been reported. No serious renal or hepatic toxicity has been reported. If pruritus and skin rashes are severe, discontinuation of treatment may be necessary. Nausea and vomiting can be mitigated with antihistaminic or antiemetic drugs given prior to MONISTAT i.v. infusion, or by reducing the dose, slowing the rate of infusion, or avoiding administration at mealtime.

Aggregation of erythrocytes or rouleau formation on blood smears has been reported. Hyperlipemia has occurred in patients and is reported to be due to the vehicle, Cremophor EL (PEG 40 castor oil).

DRUG INTERACTIONS: Drugs containing cremophor type vehicles are known to cause electrophoretic abnormalities of the lipoprotein. These effects are reversible upon discontinuation of treatment but are usually not an indication that treatment should be discontinued.

Interaction with the coumarin drugs resulting in an enhancement of the anticoagulant effect has also been reported. In cases of simultaneous treatment with MONISTAT i.v. and coumarin drugs, the anticoagulant effect should be carefully titrated since reductions of the anticoagulant doses may be indicated.

DOSE AND ADMINISTRATION:

DOSEAGE
Adults. The doses may vary with the diagnosis and with the infective agent, from 200 to 1200 mg per infusion. The following daily doses, which may be divided over 3 infusions, are recommended:

Organism	Dosage Range*	Duration of Successful Therapy (weeks)
Coccidioidomycosis:	1800 to 3600 mg per day	3 to >20
Cryptococcosis:	1200 to 2400 mg per day	3 to >12
Candidiasis:	600 to 1800 mg per day	1 to >20
Paracoccidioidomycosis:	200 to 1200 mg per day	2 to >16

*May be divided over 3 infusions.

Repeated courses may be necessitated by relapse or reinfection.

Children. A total daily dose of about 20 to 40 mg/kg is generally adequate. However, a dose of 15 mg/kg body weight per infusion should not be exceeded.

ADMINISTRATION: MONISTAT i.v. should be diluted in at least 200 ml of fluid. The diluent of choice is 0.9% sodium chloride or alternatively Dextrose 5% injectable solution. The intravenous infusion should be given over a period of 30 to 60 minutes.

Generally, treatment should be continued until all clinical and laboratory tests no longer indicate that active fungal infection is present. Inadequate periods of treatment may yield poor response and lead to early recurrence of clinical symptoms. The dosing intervals and sites and the duration of treatment vary from patient to patient and depend on the causative organism.

OTHER MODES OF ADMINISTRATION: Intrathecal. Administration of the undiluted injectable solution of MONISTAT i.v. by the various intrathecal routes (20 mg per dose) is indicated as an adjunct to intravenous treatment in fungal meningitis. Succeeding intrathecal injections may be alternated between lumbar, cervical, and cisternal punctures every 3 to 7 days. Bladder instillation of 200 mg of diluted solution is indicated in the treatment of mycoses of the urinary bladder.

HOW SUPPLIED: MONISTAT i.v. is supplied in 20 ml ampoules.

MONISTAT i.v. (miconazole) is an original product of Janssen Pharmaceutica N.V., Belgium.



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An open letter to Physicians



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Be Cautious of Large Group Practice

Guest Editorial

L. A. ARATA, M.D.
Shelbyville

DESPITE MY OFTEN REPEATED opinions of the lack of brain power shown by the Pirates of the Potomac (the Congress) and the Fuzzy Thinkers of Foggy Bottom (the Bureaucracy), I can recognize a certain cleverness in their plotting and scheming attempts to encourage large group practices under the guise of HMOs. I wave a caution flag at doctors about aiding and abetting their schemes by becoming too enmeshed in large groups.

No scheme of medical care can flourish without doctors. As individuals, doctors can be a bunch of

stubborn mavericks in their pig-headed determination to render the best patient care they are able to. Our polished halos reflect the fact that patients agree with the idea of the best care. Who polished the halos? Not the Pirates or the Fuzzy Thinkers! It was the patients!

Probably the most effective block that we can erect in the path of the scheming Pirates and Fuzzy Thinkers is our determination to maintain our independence of thought, and to care for the best interests of the one single patient in front of us at any given moment. This one-at-a-time approach does not lend itself to the bureaucratic rule book necessary for mass production. It is much easier to sell or impose the glories of "the rule book" to a large clinic business manager concerned with the bottom line of the profit-and-loss statement than it is to sell the same bill of goods to the individual pig-headed doctors who comprise the large group. If I am a cooperative member of a large group or clinic, I owe some of my allegiance to "the group;" I am expected to cooperate with the group and with the manager; I may be less able or willing to pursue my own independent thought.

As an independent practitioner, I owe my total medical thought and care to the one patient in front of me; I maintain the right to refuse all cooperation with schemes that I doubt are in the best interests of that *one* patient. I maintain that right in a way and under circumstances that do not risk hurting "the group." I risk only myself.

My thought in this matter: "In disunity is our strength."



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When exposure to rabies is suspected, Hyperab® Rabies Immune Globulin (Human) is the product of choice.

Hyperab® is recommended by the U.S. Public Health Service and the American College of Surgeons.

Antirabies serum of equine origin produces serum sickness in approximately 40% of adults and 15% of children. Anaphylactic shock may occur.

Hyperab®, the only rabies immune globulin of human origin virtually eliminates these hazards. No serious side effects have been reported with its use.

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Hyperab®
Rabies Immune
Globulin (Human)

Cutter Biological

Division of Cutter Laboratories, Inc.
Berkeley, California 94710

See next page for brief summary of
prescribing information.

Hyperab[®]

RABIES IMMUNE GLOBULIN (HUMAN)

DESCRIPTION

Rabies Immune Globulin (Human)—Hyperab[®] is a sterile solution of antirabies gamma globulin (IgG) concentrated by cold alcohol fractionation from plasma of donors hyperimmunized with rabies vaccine. Hyperab[®] globulin is a 16.5% \pm 1.5 solution of gamma globulin from venous blood in 0.3M glycine, preserved with 1:10,000 Thimerosal (a mercury derivative). Its pH is adjusted with sodium carbonate. The product is standardized against USA Standard Antirabies Serum. The USA unit of potency is equivalent to the International Unit (IU) for rabies antibody.

This product is prepared from human venous plasma. Each individual unit of plasma has been found nonreactive for hepatitis B surface antigen using the radioimmunoassay method of counter-electrophoresis.

INDICATIONS

Treatment of rabies, once clinical disease becomes apparent, is rarely if ever successful. Rabies vaccine (duck-embryo origin, Lilly Laboratories) with or without Rabies Immune Globulin (Human)—Hyperab[®] should, therefore, be given to all persons suspected of exposure to rabies, particularly to severe exposure. Whenever possible, Hyperab[®] globulin should be injected as promptly as possible after exposure. If initiation of treatment is delayed for any reason, however, Rabies Immune Globulin (Human) should be given just the same, regardless of the interval between exposure and treatment.

Rabies virus is usually transmitted by the bite of a rabid animal, but can occasionally penetrate abraded skin with the saliva of infected animals. Progress of the virus after exposure is believed to follow a neural pathway, and the time between exposure and clinical rabies is a function of the proximity of the bite (or abrasion) to the central nervous system and the dose of virus injected. The incubation is usually 2 to 6 weeks, but can be longer. After severe bites about the head and neck, it may be as short as 10 days.

After initiation of the vaccine series, it takes 2 weeks or longer for development of immunity to rabies. Since most vaccine failures have occurred in cases of severe exposure, the value of immediate immunization with preformed rabies antibody cannot be over-emphasized.

Recommendations for use of passive and/or active immunization after exposure to an animal suspected of having rabies were detailed by WHO, and by the US Public Health Service Advisory Committee on Immunization Practices (ACIP).

INJECTION PROCEDURE

A portion of the Hyperab[®] globulin dose should be used to infiltrate the wound. The rest is injected intramuscularly.

CONTRAINDICATIONS

Rabies Immune Globulin (Human)—Hyperab[®] is contraindicated in repeated doses, once vaccine treatment has been initiated. Repeating the dose may bring about interference with full expression of active immunity expected from the vaccine. Hyperab[®] globulin is also contraindicated in individuals who are known to have an allergic response to gamma globulin or thimerosal.

PRECAUTIONS

NEVER ADMINISTER Hyperab[®] globulin INTRAVENOUSLY.

ADVERSE REACTIONS

Slight soreness at the site of injection, and slight temperature elevation, may be noted at times. Sensitization to repeated injections of human globulin is extremely rare.

In the course of routine injections of a large number of persons with human gamma globulin, there have been a few isolated occurrences of angioneurotic edema, nephrotic syndrome, and anaphylactic shock after injection. Because of their rarity, it is difficult to determine whether such reactions are incidental, or causally related to the gamma globulin.

No instances of transmission of hepatitis B (homologous serum jaundice) have been reported from the use of human gamma globulin prepared by the fractionation methods employed by Cutter Laboratories, Inc.

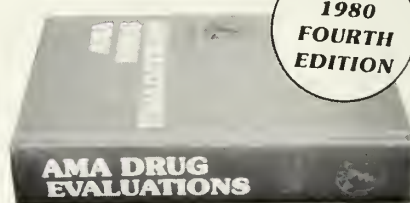
HOW SUPPLIED

Rabies Immune Globulin (Human)—Hyperab[®] is packaged in 2-ml and 10-ml vials with a potency of 150 International Units per ml (IU/ml). The 2-ml vial contains a total of 300 IU which is sufficient for a child weighing 15 kg (33 lb). The 10-ml vial contains a total of 1500 IU which is sufficient for an adult weighing 75 kg (165 lb).

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An Open Letter To All Doctors

DAVID B. HORNER, M.D.
President
Los Angeles County Medical Association

Note: This letter was written in a response to a letter of resignation submitted by a member of the Los Angeles County Medical Association who was upset by a dues increase. The letter was apparently persuasive because the member sent in a check and remains in good standing.

Dear Doctor:

I regret you feel the combined LACMA-CMA-AMA plus LACMA District dues are more than you wish to pay. I, too, regret that the "bottom line" approached \$1,000, just as I regret that everything we purchase today is more expensive than it was one, five or ten years ago. With double-digit inflation, it is an unavoidable fact of life.

I can assure you that—so far as LACMA's dues are concerned—the Board of Trustees weighed all factors in determining the amount of our dues for 1980. The same holds true for the CMA and the AMA (whose dues, incidentally, did not increase for 1980).

As one who voluntarily devotes considerable time to defending medicine—and its practitioners and our patients—from the increasing inroads of government intervention and attacks from all sides, I am distressed when some physicians feel they cannot afford (or choose not) to spend (considering the tax deductibility of the amount) a couple of dollars a day to preserve the freedom of our profession.

Reprinted by permission,
LACMA PHYSICIAN, Feb. 11, 1980.

At the local, state and national levels, *only* LACMA, CMA and the AMA are fighting this battle for all of us—including those who opt not to pay dues to support the efforts.

I hope I don't need to tell you how heavily LACMA is involved in a wide range of activities, from dealings with the County Board of Supervisors and dozens of local issues, to defending our members against unfair accusations by BMQA, the media, lawmakers or our wild-eyed Governor. If you have doubts, simply review the past years' issues of LACMA PHYSICIAN. I can assure you that we will continue to uphold the profession's interests—whether it's over stupid, ill-conceived Medi-Cal claim forms or the state's granting improper hospital privileges to mid-level practitioners. All physicians, including those who come along on a "free ride" by paying no dues, will—and do now—benefit from our activities.

There is no "fat" in LACMA's budget. Our percentage of payroll to total expenses today is less than it was in 1976. At the same time, we are increasing the amount of non-dues revenue vs. dues, as a means of offsetting future dues increases by generating more income from business and other services.

Inflation is, of course, our biggest problem—just as it is for you and every physician who must meet an increasing overhead, pay more and more in taxes, and compensate employees with a living and competitive wage.

The Board of Trustees looked at some very revealing figures recently. We discovered that—based on the actual rate of inflation for the past five years—LACMA's expense figures would have to increase by approximately 75% just to stay even.

CONTINUED ON PAGE 319



Tom Sneva (facing camera) enters one of 19 ambulances at the Indianapolis Motor Speedway after being involved in an accident near the end of last year's 500-Mile Race. Any time a driver even brushes a wall, he takes a trip to the track hospital for a check-up. Incidentally, Rick Mears won the 1979 international speed classic.

Indianapolis Motor Speedway:

Where 125 Doctors Are 'IN' On Race Day

IF YOU'RE GOING to get sick or injured, perhaps the best place to do so is at the Indianapolis Motor Speedway on Race Day.

That may seem to be a peculiar statement, but truth is often stranger than fiction.

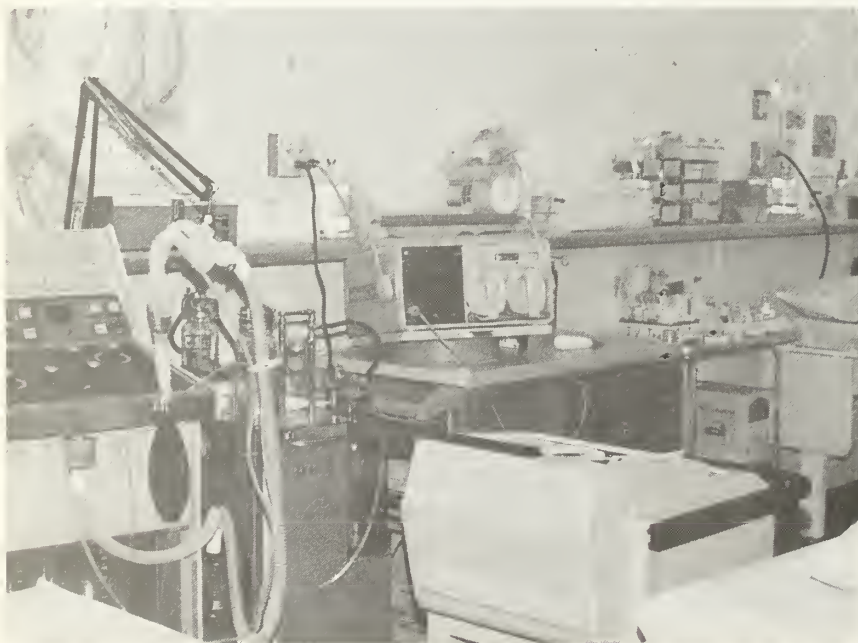
The fact is that on Race Day—set this year for Sunday, May 25—there are more physicians, nurses and emergency medical technicians gathered in the immediate vicinity of the 2½-mile oval track than there are at any one time in most American hospitals.

Heading up the entire emergency medical establishment is Dr. Thomas A. Hanna, a family physician who has been the Speedway's medical director since 1960. His Race Day medical crew consists of up to 125 physicians, 125 nurses, more than 40 EMTs and respiratory therapists, a half dozen laboratory and x-ray personnel, and about six clerical staffers—and almost all of them are volunteers.

Together, they operate a well equipped infield hospital, three "sub-hospitals," and seven or so

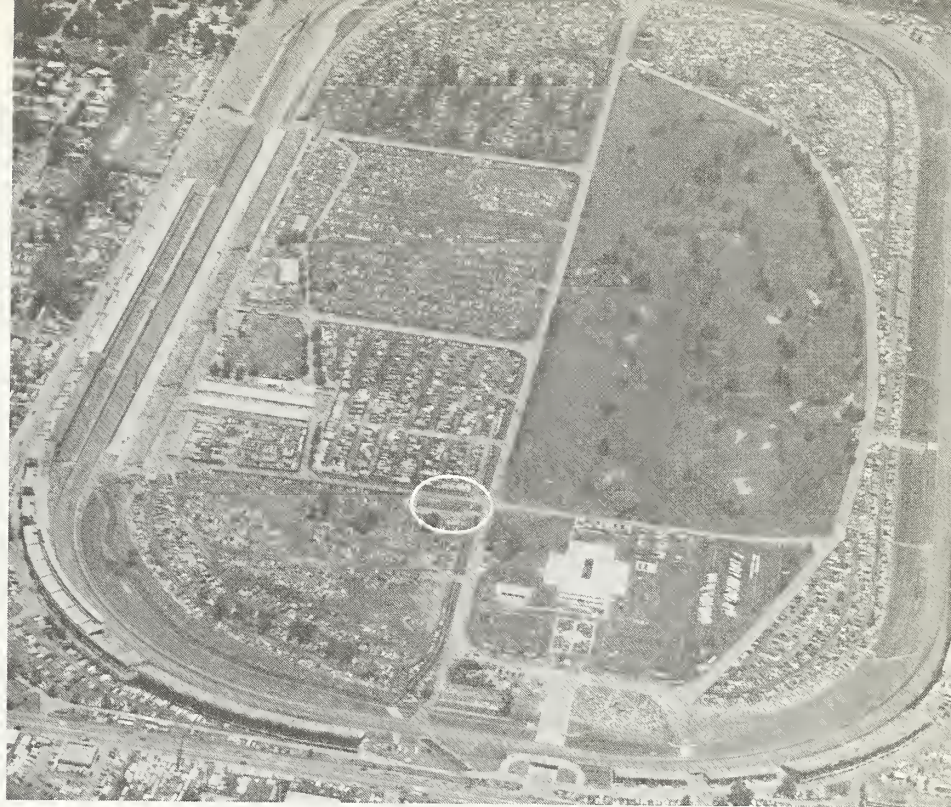
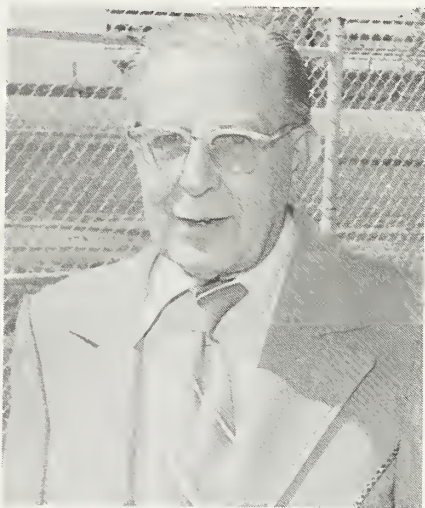
first-aid stations. Standing by are 19 ambulances and up to 2 helicopters—all for emergency runs to Indianapolis' Methodist Hospital, or any other nearby hospital, in the event that becomes necessary.

But the infield hospital is considered so excellent that most emergencies can be handled on the spot. It features 10 treatment cubicles, including intensive-care facilities, and a 21-bed recovery room, as well as x-ray and laboratory services. First-aid stations, located throughout the Speedway grounds, are each staffed by an RN and EMTs; each has about six cots. On Race Day, physicians are everywhere; many are seated among the crowd of nearly 300,000 spectators.



The clientele at the well equipped emergency room of the track's field hospital are mostly spectators. Most of the large equipment is on loan from various manufacturers for the month of May.

The track hospital (circle) is located in the infield of the Speedway's 2½-mile rectangular race track. The track, seven miles northwest of the center of Indianapolis, occupies 559 acres of ground. Dr. Thomas A. Hanna (below) is the Speedway's medical director.



To Serve About 300,000 People

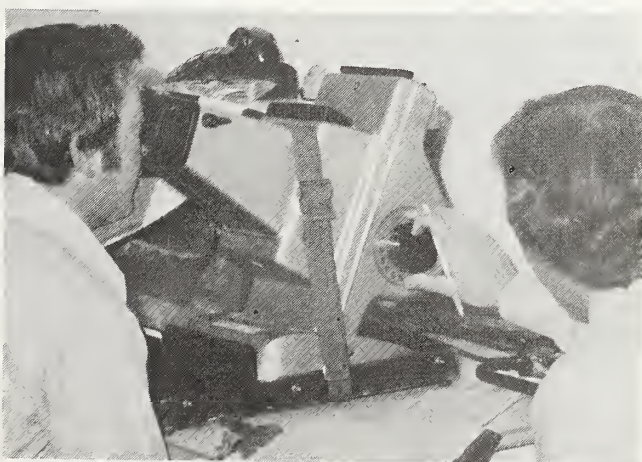
Even parking and security personnel are part of the emergency medical team, having been taught CPR techniques; they are told how to contact EMS personnel to get them quickly to an emergency.

"I think you can safely say that our hospital here at the track is better equipped than many small-town hospitals," Dr. Hanna says. "We have to be ready and equipped to handle almost any kind of illness, injury or emergency."

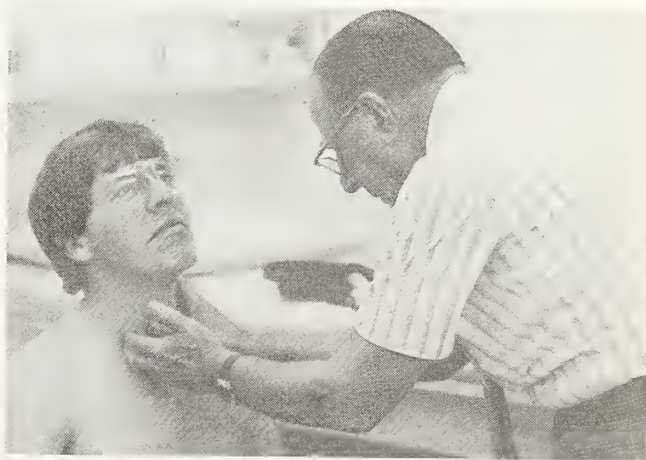
Obviously, the primary medical concern at the Speedway is for the race drivers, but the same type of care is extended to fans. On Race Day, as many as 1,500 people may be treated at the track's facilities. "We treat everything from cuts and lacerations to heart attacks, diabetic problems, broken bones and injuries to the participants," Dr. Hanna says. He points out that there hasn't been a cardiac fatality at the track on Race Day in three years, attrib-

uting this success rate to his personnel and equipment.

Most of the large equipment is on loan from various manufacturers for the month of May. The major receiving unit is Methodist Hospital, with Winona Memorial Hospital providing the x-ray machine. St. Vincent and I.U. Hospitals provide administrative, student and nursing personnel, while St. Francis Hospital provides nursing and ancillary personnel.



Driver Gary Bettenhausen (left photo) has his eyesight examined at the track hospital while driver Tom Sneva (right photo) is

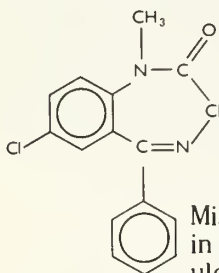


checked by Dr. Hanna. All drivers must have a complete physical examination 30 days before the race.

Aspects of Management

What to tell your patients when you prescribe Valium® (diazepam/Roche)

Survey shows significant correlation between comprehension and compliance



A study of compliance patterns reveals that more than 6 out of 10 patients made errors in self-administration of prescribed medication, largely due to lack of comprehension.*

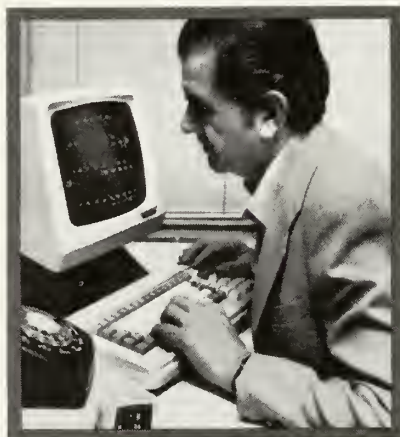
Misunderstanding of directions resulted in discrepancies in dosage schedules as well as in length of therapy.

Since evidence suggests that expanded verbal instructions may encourage compliance, the patient receiving Valium can benefit from your explanation of the dosage regimen, what response to expect from therapy and when to expect it.

What Valium (diazepam/Roche) can do

Your patients should know that 1) you are prescribing Valium as an adjunct to an overall program for the treatment of anxiety, and 2) Valium is given to relieve the symptoms of excessive anxiety and psychic tension while you help the patient to explore and deal with the underlying cause of his psychic tension.

Patients often interpret manifestations of anxiety, such as palpitations, hyperventilation, fatigue and muscle tension, as symptoms of a serious disease. However, when they



learn that these symptoms can be relieved by Valium therapy, patients can more readily understand the psychosomatic origin of their symptoms and to accept the nonpharmacologic measures you may recommend.

The time you devote to these explanations can be a therapeutic measure in itself. Most anxious patients respond to and benefit from a frank discussion with an objective, sympathetic professional.

At the start of treatment, establishing therapeutic goals helps the patient to learn *what* to expect and *when* to expect it. Patients should also be informed that the medication will be gradually reduced and discontinued upon attainment of the therapeutic goal.

Tapering of dosage is rarely necessary in short-term therapy, but when consistently higher doses are used for extended periods, patients should know that the gradual reduction of medication will be implemented in order to avoid sudden recurrence of symptoms or possible withdrawal symptoms.

Such recurrence is unlikely when the causes of the anxiety have been worked out satisfactorily within your overall treatment program.

What Valium (diazepam/Roche) can't do

It should be emphasized that there is no "magic" in any antianxiety tablet; that medication is not prescribed as a problem solver. Instead, Valium is being prescribed as a *temporary measure to relieve symptoms* generated by excessive anxiety and psychic tension.

* Boyd JR, et al: *Am J Hosp Pharm* 31: 485-491, May 1974

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms, or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology, spasticity caused by upper motor neuron disorders; athetosis, stiff-man syndrome, convulsive disorders (not for sole therapy). The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders,

possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication, abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage In Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics,

Practical pointers on taking antianxiety medications

do's Patients should be instructed to keep to their dosage schedule exactly as prescribed. If they miss a dose, they should not try to make it up by taking two doses the next time. Ask them to contact you promptly if they experience worrisome side effects.

Explain that drowsiness is a common reaction to almost all calming agents, but that it usually subsides in a few days. Urge the patient to contact you for a possible dosage adjustment if drowsiness or other reactions persist.

Just as you request a complete list of all medications the patient is taking, suggest that this list be given to any other physician treating her/him.

Like all medicines, Valium should be kept out of reach of children and young people. Old or unused medication should be discarded.

and don'ts Since drowsiness is an occasional problem, patients should be advised against driving or operating hazardous machinery until they see how the medication affects them. They should also know that tranquilizers increase the effects of alcoholic beverages, which should therefore be avoided. Also, warn patients against simultaneous use of drugs that depress the central nervous system, particularly sedative hypnotics.

Patients should be aware of the importance of not sharing their medications with friends and neighbors; they should know that what you have prescribed for them may be contraindicated for others.

2-mg, 5-mg, 10-mg scored tablets
Valium[®]
diazepam/Roche
An important adjunct to your
treatment program for excessive
psychic tension

Dosage: Individualize for maximum beneficial effect. *Adults:* Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed, adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. *Geriatric or debilitated patients:* 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) *Children:* 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium[®] (diazepam/Roche) Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500, Tel-E-Dose[®] packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10, Prescription Paks of 50, available in trays of 10.

ROCHE

Roche Laboratories
Division of Hoffmann-La Roche Inc.
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American Medicine: Challenge for the 1980's

A Special Book Review

PAUL S. RHOADS, M.D.
Richmond, Ind.

Following is an in-depth review of "American Medicine: Challenge for the 1980's," by David E. Rogers, M.D. Ballinger Press Co., Cambridge, Mass. Copyright 1978. 150 pages.

IT IS ALWAYS USEFUL to stop momentarily to reflect on where we have been going during the past few years and give some thought as to what is ahead. There can never be unanimity of opinion, particularly among physicians, upon progress in health care. However, this fact laden treatise by a physician of the stature of Dr. David Rogers should help us get our thoughts in order as we form our judgments. Rogers' background includes 10 years as professor and chairman of the Department of Medicine at Vanderbilt, dean of the faculties and vice-president of Johns Hopkins Medical School for four years after leaving Vanderbilt, and since then physician-president of the Robert Ward Johnson Foundation, a philanthropy devoting its resources to bettering the health and medical care of Americans. Along with his constant teaching activities, he has carried on solid research, especially in the field of infectious diseases.

Rogers points out that in the 1960s there was wide interest in expanding and improving our facilities to the point that good health care could be provided for *all* of our citizens. With the naive idea that with enough money spent on research, most of the problems could be solved, generous government grants were made to practically all medical institutions, and more attention was paid to devising ways for a larger segment of our population to gain access to medical care. It became apparent a maldistribution of physicians contributed significantly to this latter problem. Also, there came the realization that along with the phenomenal increase in medical technology there had been a steady decline in the human caring, "the Samaritan function," of the deliverers of

medical care. A different "image" of the physician, as a compassionate friend and healer, had emerged. In a nation bewildered and disillusioned by a decline in morality, energy depletion, inflation and other social ills, discouragement with the performance of physicians and their professional allies was inevitable.

Public programs such as neighborhood health centers, public clinics for children and young mothers, mental health treatment centers and the like came into being and are still proliferating. In the 1970s, the changing role of hospitals began to be recognized. More and more, with advances such as artificial kidneys, cardiac pacemakers, fiberoptic endoscopy, more and better antibiotics and other drugs, better training of paramedical personnel, it began to be recognized that the role of hospitals should be the *cure* of the sick rather than the *care* of the sick only. More and more individuals began to go to hospitals and clinics because access to individual physicians was often difficult and the care received from them inadequate.

As the 1970s wore on, our pre-occupation with the costs of health care necessarily increased. This has come about for a variety of reasons—too complex to be dealt with even superficially here. But the massive intrusion of the government into health affairs, and the growing conviction that every citizen has the *right* to health care, whether he can pay for it or not, have resulted in enormous expenditures that were not anticipated. Also, the numbers of persons required to deliver health care has increased three or fourfold, and their salaries continue to rise. These developments, and the enormous cost of new technologies such as the CT scanner, monitoring of heart and brain function, microscopic brain surgery and the like, have put the cost of medical care out of the reach of the ordinary citizen. Unfortunately, the trend toward higher and higher costs will not change in the foreseeable future.

Yet, as Dr. Rogers points out, many gains have been made. In the 1930s, persons with

low incomes saw physicians less than half as often as those in better circumstances. In 1960, this ratio had changed, so that the disadvantaged saw physicians 16% less often than the well-to-do. In 1975, those with low incomes making visits to physicians averaged six times per year as compared to five visits for the higher income group. In 1966, black Americans saw physicians 31% less often than whites. Now each race sees physicians about as frequently as the other.

Certain diseases have pretty well come under control—tuberculosis, syphilis, poliomyelitis, bacterial pneumonias, puerperal fevers—and many others. On the other hand, little real progress has been made in the cure of cancer, coronary artery disease, crippling arthritis, diabetes, multiple sclerosis, and many others equally incapacitating.

It is of considerable interest that, with Medicare and Blue Cross available, plus a host of private insurance carriers, 93% of individuals now have some form of health insurance. This, too, has, of course, been an important factor in increasing medical costs. People have demanded more and more in the way of sophisticated tests and service since a third party foots the bill, and physicians, being human, have acquiesced partly in the interest of not missing anything in a diagnostic way, and partly to avoid malpractice suits.

The problems outlined above, and many others not even mentioned, are being studied by government at the national and state level, all medical schools and many institutions such as the Robert Ward Johnson Foundation, which Dr. Rogers represents. No easy solutions are on the horizon, but there are some hopeful signs. With government help at both the national and state level, between 1966 and 1976 the number of physicians in training increased by 70%. In 1976, 60,000 young people were enrolled. During this period, the make-up of the classes also changed. The percentage of women changed from 8 to 25%, and blacks from 2.5 to 9%. Nursing schools increased their enrollment by 90%. Physician assistants (mostly recruited from the nursing field) were practically non-existent in 1966. In 1976, 55 institutions were offering physician assistant training. At least 6,000 are now in practice.

Although there is no proof that improving access to medical care has made the difference, there is some evidence that the overall health of Americans is improving. In 1968 the annual death rate stood at 746.7 per 100,000 of population. In 1975 it had dropped to 642.1 per 100,000. Similarly, infant death rates fell by 42% along with maternal mortality, which dropped from 37 to 14.5 deaths per 100,000

live births. In the 12-year period 1963 to 1976, the death rate from coronary artery disease dropped 23%. All of these are encouraging signs, but monumental problems in the delivery of health care remain.

In Dr. Rogers' view the urgent tasks to be undertaken include:

1. *Halting the escalating costs of medical care without reducing it in quality or availability.* In 1966 the estimated expenditure was \$180 per person per year. In 1975 we spent \$552 per person, \$2,300 per family unit, which was 7.5 to 10% of each family's income.

2. *Improving the health of children, particularly those of poor families.* School surveys show that about 30% of children have learning or behavioral difficulties, most of which are due to physical disabilities. Of course, socioeconomic problems such as broken homes (1 in 6), mothers with jobs outside homes (1 in 2), alcoholism, etc., contribute importantly to these health problems.

3. *Improvement in the care of the elderly.* About 5% of old people are in nursing homes, a high percentage of which are woefully substandard. A great many more have no medical care at all.

4. *Improvement in delivering medical care to dwellers in rural communities.* Both physicians and nurses can work more comfortably in urban areas, and are concentrated there. People in the country more often than not can obtain medical care only by traveling many miles, and are totally bereft of rapid emergency care.

5. *Care of the chronically ill.* These sufferers are, to a significant degree, neglected because many cannot get to physicians' offices and clinics, and also because good treatment for them still has not been devised.

6. *Improvement in care and facilities for handicapped persons.* With few exceptions, these people are still largely neglected. A few cities and states have enacted building codes which enable them to get about on city streets, gain access to public telephones and toilet facilities and the like, but their plight has really improved very little. Rehabilitation centers are very helpful to these people, but there is a woeful shortage of such institutions.

Among the remedies suggested by Dr. Rogers are the following:

- Ambulatory care should replace much of the expensive hospital care now being utilized. Health care facilities such as the Kaiser-Permanente Institution have shown that two hospital beds per 1,000 enrollees are sufficient for the people they serve as against five beds per 1,000 for the country at large.

- Medical schools—particularly state insti-

tutions in addition to their purely teaching and research responsibilities—should care for people 24 hours a day and put much more emphasis on teaching students how to provide ambulatory care. Much of this teaching would have to be done in affiliated community hospitals in which students would deal with “run of the mine” medical disorders of the kind they would later see in their own offices. Of course, experience with the more difficult problems now referred to large medical centers also would have to be provided—as is now done. The author feels that cost consciousness should always be in the minds of medical teachers, and constantly reinforced as they instruct their students. It is estimated that at the present time, each practicing physician generates \$200,000 to \$350,000 in medical costs each year. Much of this could be eliminated by better history taking and physical examination and by more selectivity in ordering tests.

- The trend toward regionalizing of highly sophisticated and expensive technology must be continued despite the desire of each hospital to have as much equipment of this kind as possible. The HSA organizations throughout the country were created primarily to deal with this problem. Their efforts often are severely handicapped by physicians who are thinking of the prestige of their own hospitals, rather than the matter of conservation of government funds and medical and paramedical personnel.

- The experiments in which medical students are required to work for two years in underserved areas in fulfillment of financial obligations to medical schools and government have been highly successful. If such practices were required of *all* medical students after their formal training is over, many of the problems of caring for rural and ghetto residents would be eliminated. In such settings the necessity for economy in delivery of medical care would be reinforced. Also, a certain number of such young physicians might find that country or ghetto practice was rewarding enough to make them want to remain in such communities indefinitely.

- The potential for utilization of non-medically trained volunteers should be more thoroughly examined and used. The author points out that still healthy retirees, young people without jobs and many others yearning to be usefully employed, even if the pay were minimal, could be utilized to monitor handicapped and chronically ill people. Often they could administer some help themselves. If not, they could, at least, bring to the attention of health professionals the needs of the people they are calling upon. Hospital volunteers constitute an important part of the total work force. They could be equally useful in ambulatory settings.

In other sections of the book, Rogers explores the problems of medical schools as they struggle to cope with the problems of the 1980s. Like every dean or former dean, he is keenly aware of the interference with the internal affairs of every institution of higher learning that receives financial support from the government. Under present circumstances, few of the schools could survive without federal and state funds, which obviously are going to be monitored to some extent by those who award the funds.

No attempt in this review will be made to go much further into the multitude of problems faced by the medical schools which Rogers touches upon, but one of them is too important to be entirely passed over. That is the selection of students for medical school training. For years, admission committees have struggled with this most important problem of all. All agree that only students with better than average scholastic records should be considered. Sizing them up for the other attributes which every good physician should have requires unusual insight and consumes more time than many busy physicians are in position to devote to it. Does the candidate have scientific curiosity, a real concern for the welfare of his fellow human beings, the ability to cope with trying situations without being discouraged, sustained enthusiasm, the capacity for sustained hard work, and a good sense of values in which the acquisition of money plays a minor role? To quote Rogers—“that which is measurable may be driving out that which is more important.” The answers to such questions as those posed above are not easily gleaned from medical aptitude tests or even single interviews with each candidate. Talks with peers, high school and college teachers, Boy Scout leaders, ministers, and parents would be helpful but are not always practical. The problem is compounded by the fact that a certain number of young people from disadvantaged groups who have not had the advantages of good schooling and social contacts enjoyed by most candidates must be admitted if state capitation rules are to be met. Despite their handicaps, many good doctors emerge from such groups.

Taken altogether, this treatise on “American Medicine—Challenge for the 1980’s” gives a good overall view of the problems faced by medicine in the next decade. While few definitive answers are given, it provides much food for thought. Even though we are in a period when we are inundated with books and journals, many of which have real relevance to our professional activities, this reviewer thinks every medical teacher and every practitioner should take the time to read Rogers’ book.



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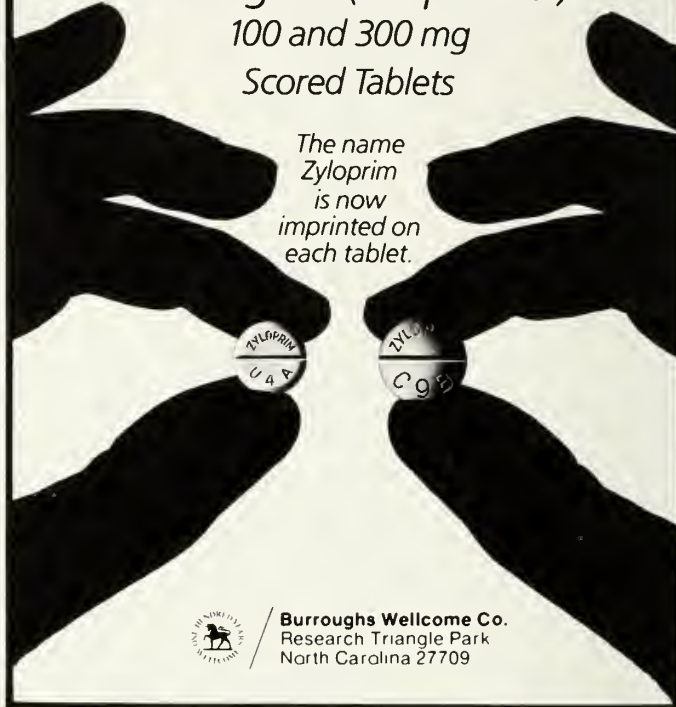
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CLINICAL NOTES

The Etiology of Psoriasis

A few years ago, an internist friend asked me, "When are you people going to find the cause of psoriasis?" I told him we hoped to accomplish this by the time his people found the etiology of rheumatoid arthritis. The picture in both diseases today is much clearer, although the final chapters probably have not been written.

It seems that everyone doing basic research in dermatology applies any new finding to the etiology of psoriasis. The cause has been attributed to an alteration in enzyme activity as well as to changes in levels of cyclic nucleotides and polyamines. However, at present, a better case probably can be made for an immunologic etiology.¹

Histologically, psoriasis is characterized by microabscesses in a parakeratotic stratum corneum, elongation of the rete ridges and dermal papillae, thinning of epidermis over large dilated capillaries in the papillary dermis, and an inflammatory infiltrate. Immunofluorescence shows antibodies in the stratum corneum overlying the engorged capillaries.² These antibodies can be found in normals, but the pattern in psoriasis is impressive. Psoriatic stratum corneum is chemotactic probably from C5a,³ or C3a deposited because of the stratum corneum antibodies. This chemotaxis would explain the characteristic Munro microabscess.

If psoriasis is indeed an immunologic disease, then there should be some alteration in those who suffer from it. Numerous studies attest to the inheritability of psoriasis. The disease is associated with certain major histocompatibility antigens particularly at the B locus. Usually B₁₃, B₁₇, or B₂₇ will be found in a higher percentage than one would expect by chance but rarely other B antigens have been reported in certain families. There also is some evidence that certain antigens at the C and D loci occur more frequently in patients with psoriasis.⁴ Alterations in immunologic response also have been reported to occur in psoriatics, but whether this is a primary or secondary event is a question.

Grabar⁵ has described an auto-antibody that he terms physiologic. Some believe physiologic antibodies are present in small numbers where they are needed to facilitate removal of breakdown products of damaged or dying tissue. In other words, they are there to "pick up the garbage." In theory, they should be kept in check by T suppressor activity, but in some patients with auto-immune disease they may occur in greater

amounts or with greater efficiency. Thus, this sub-microscopic garbage collector tries to take the house along with the trash. If we assume this occurs in psoriasis, some long-awaited answers begin to unfold.

Psoriasis classically occurs in areas of injury (Koebner phenomenon). By experimentally injuring the skin of patients with psoriasis, it is possible to follow the chain of events.¹ The antibodies invading the damaged stratum corneum are primary and are soon followed by complement deposits. There is an engross of polymorphonucleated leukocytes, which is followed in turn by the clinical disease. This may then explain why psoriasis occurs more frequently in cold and dry climates and why it is better in the summer than in the winter. It also is known among dermatologists that pustular psoriasis most commonly occurs on the palms and soles, and this may be due to the increased amount of substrate present.

But why should someone with psoriasis improve on dialysis? This also may have an immunologic basis. Dialysis causes production of an antibody to C5a.⁶ This could prevent availability or movement of C5a into the stratum corneum, interrupting the previously described chain of events.

Once the pathologic process is started, the epidermis proliferates in much the same way as the repair process in injured skin. However, in psoriasis it does not switch off and become self-perpetuating. Ultraviolet light therapy, PUVA therapy, and perhaps antimetabolic therapy then may be directed more toward the inflammatory cell than we previously had thought.

There are numerous areas upon which one could speculate with interest, such as why guttate psoriasis follows a strep infection or how emotion or pregnancy might induce change. It will be interesting to follow the progress of research in these areas in the coming years.

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THE JOURNAL offers its readers a Continuing Medical Education series of articles prepared by the faculty of the Indiana University School of Medicine. The program is coordinated and supported by a grant from the school's Division of Continuing Medical Education.

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Treatment of Anxiety States: Some Theoretical and Practical Aspects

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THE TERM ANXIETY in both professional and lay usage has many different connotations. It can refer to an emotional state, which may or may not be normal. It is used to describe a symptom that can be associated with almost any psychiatric or non-psychiatric disorder. It can describe a syndrome. It can refer to a character trait. It also can describe a concept. Indeed, anxiety is the lynchpin in the constructs of both psychoanalysis and behavior theory. This bewildering variety of meanings can lead to much confusion and misunderstanding among clinicians and patients.

Normal anxiety is ubiquitous. It functions as an alerting signal, a warning of impending danger, and as such can be at times life saving. It

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Anxiety disorders constitute one of the most common of the psychiatric disorders. The prevalence rate for life-long anxiety states in the community is approximately 5%. They frequently pose a diagnostic problem for physicians because of their associated physiological symptomatology. The most common complications in patients with anxiety disorders are substance abuse and/or alcoholism. All anxiolytic agents have the potential for producing psychological dependence. The physician's role in treatment consists of careful evaluation, including the collection of physical, historical and mental status data, judicious, short-term use of medication and attempts at psychosocial intervention.

is not always unpleasant. In fact, mild degrees of anxiety can be exhilarating. It can sharpen intellectual and physical performance and is an extremely powerful motivator of human behavior. More severe degrees of anxiety, however, are experienced as diffuse, unpleasant, vague feelings of apprehension or dread. They are usually accompanied by one or more bodily sensations that characteristically recur for the same person; for example, an empty feeling in the pit of the stomach, tightness in the chest, pounding heart, perspiration or a sudden urge to void. These are associated with marked motor restlessness. Anxiety is considered pathological when it reaches such intensity that individual functioning is impaired. It also can be considered pathological when the maneuvers the individual undergoes to achieve anxiety reduction (in psychodynamic terms, defense mechanisms) lead to self destructive or non-adaptive behavior.

Fear has been differentiated from anxiety on the basis of the origin of the threat. Is the threat known or unknown, external or internal, immediate or future, definite or vague, nonconflictual or conflictual? The physiological response to fear is mixed parasympathetic-

sympathetic. The immediate reaction is often primarily parasympathetic with decreased heart rate and blood pressure, which may result in syncope. As the state continues, sympathetic discharge quickly gains dominance, producing a clinical picture similar to that described in anxiety.

SYNDROMES OF ANXIETY DISORDERS

In the new Diagnostic & Statistical Manual of Mental Disorders (D.S.M. III), which will be released this year, an attempt has been made to clarify descriptions of diagnostic entities in order to aid diagnosis and treatment. Anxiety Disorders in D.S.M. III are subdivided into: a) Phobic Disorders, b) Panic Disorders, c) Obsessive Compulsive Disorders, d) Generalized Anxiety Disorders, and e) Atypical Anxiety Disorders.

Since obsessive compulsive disorders comprise, at least to these authors, a unique syndrome, this will not be discussed further here.

Phobic disorders are further subdivided into three types: agoraphobia, the most common and most severe form; social phobia; and simple phobia.

Agoraphobia is a phobic disorder in which the predominant disturbance is an irrational fear of leaving

the familiar setting of the home. It is often preceded by recurrent panic attacks. The individual develops an anticipatory fear of helplessness when having a panic attack and is therefore reluctant or refuses to be alone, particularly in unfamiliar situations. These fears are pervasive and dominate the individual's life so that a large number of situations are entered into only reluctantly or are avoided. In the severe form of the disorder the individual is "housebound." At home the individual can feel quite comfortable, however. Commonly, such individuals insist on company whenever they leave the home. Depression, which can be severe, anxiety, rituals and ruminations are frequently present. Age at onset is most frequently in the late teens or early 20s but may be much later. The severity of the disturbance waxes and wanes and may be episodic. In addition, from day to day the activities or situations that the individual dreads may change.

In social phobia, the individual shuns social occasions to avoid the possibility of humiliation or embarrassment. The most common phobias include fear of public speaking, blushing, eating or drinking in front of others, or using public lavatories. Often a vicious circle is created in which the irrational fear generates anxiety that impairs performance and thus provides an apparent justification for avoiding the phobic situation. This disorder often begins in late childhood or early adolescence. The course is usually chronic and may undergo exacerbations and remissions. Except when the disorder is severe, it is rarely incapacitating by itself. However, it can stand in the way of economic and professional advancement.

In simple phobia the essential feature is fear and avoidance of an object or situation other than those previously described. The most common simple phobias involve

animals, particularly reptiles, insects and rodents. Other simple phobias are claustrophobia and acrophobia.

The phobic object or situation is reacted to as if it were dangerous or humiliating with consequent marked anticipatory anxiety and avoidance behavior. Onset is usually in childhood, especially in animal phobias. The course is usually quite chronic. The degree of impairment is variable and depends upon the natural characteristics of the phobic object or situation. Simple phobias concerning snakes are easily avoided. However, simple phobias such as elevator phobia may provide considerable problems to businessmen or salesmen who must enter tall buildings in the course of their work.

In panic disorders, the essential feature is recurrent panic (anxiety) attacks and nervousness. In general, the symptoms are characteristic of widespread, sudden, autonomic discharge. The panic attacks are manifested by discrete periods of sudden onset of intense apprehension, fearfulness or terrors often associated with feelings of impending doom. The most common symptoms experienced during an attack are dyspnea, palpitations, chest pain or discomfort, choking or smothering sensations, dizziness, vertigo or unsteady feelings, feelings of unreality (depersonalization or derealization), parathesias, hot and cold flashes, sweating, faintness, trembling or shaking, and fear of dying, going crazy or doing something uncontrolled during an attack. Attacks usually last minutes or, more rarely, hours.

The individual with a panic disorder is never certain when a panic attack is likely to occur. Commonly, the individual develops an anticipatory fear of helplessness during a panic attack and therefore is reluctant to leave the familiar surroundings of the home. This may

lead to the clinical picture of agoraphobia. When a series of attacks continue, the individual often develops varying degrees of nervousness and apprehension ("free floating anxiety") between the attacks. The disorder often begins in late adolescence or early adult life but may first occur in the 30s or 40s.

Panic disorder is recurrent and episodic and occasionally may become chronic. Except when the disorder is severe, it is rarely incapacitating by itself. To make the diagnosis of panic disorder, the individual must experience at least three panic attacks occurring within a three-week period and occurring at times other than during marked physical exertion or life-threatening situations and in the absence of a physical disorder that could account for the symptoms.

In general anxiety disorders, the essential feature is chronic (at least 6 months), generalized and persistent anxiety without the specific symptoms that characterize the previously described disorders. The anxiety is manifested by chronic, autonomic hyperactivity.

Although the specific manifestations vary from individual to individual, evidence of anxiety could be present in at least three of the following four categories: motor tension, autonomic hyperactivity, apprehensive expectation, vigilance and scanning. Motor tension may be manifested as shakiness, jitteriness, jumpiness, trembling, tenseness, muscular aches, easy fatigability and inability to relax. Sighing respiration is common. Autonomic hyperactivity may be manifested by a wide variety of somatic complaints including sweating; pounding of the heart; racing of the heart; cold, clammy hands; dry mouth; dizziness; light-headedness; tingling in the hands or feet; upset stomach; hot or cold spells; frequent urination or defecation; diarrhea; discomfort in the pit of the

stomach; lump in the throat; flushing; pallor; high resting pulse and respiration rate. The individual is usually apprehensive and continually worries, ruminates, and anticipates something bad happening either to himself or to valued others. The individual may be on edge, impatient, or irritable. He may complain of distractibility, insomnia, difficulty falling asleep, interrupted sleep, unsatisfying sleep and fatigue on awakening. Mild depressive symptoms are common. The disorder usually begins in adolescence or young adulthood. The long-term course is unknown. There may be mild impairment in social or occupational functioning, but it is rarely incapacitating by itself.

The diagnosis of atypical anxiety disorder is used when the individual appears to have an anxiety disorder that does not fulfill the criteria for any of the above specified conditions.

EPIDEMIOLOGY, COURSE AND OUTCOME

The prevalence of anxiety-related disorders in the population is difficult to determine with any certainty owing to a number of factors including the lack of consensus on and clarity in the description of the anxiety-related syndromes until recently and the lack of any universally accepted, well validated method for measuring anxiety in subjects. Nevertheless, it is probable that anxiety syndromes constitute one of the most common of the psychiatric disorders. Certainly, enormous amounts of anxiolytic medication are prescribed and consumed in this country. In 1977, Valium® was the most frequently and Librium® the fourth most frequently prescribed drug.

A British survey using the Morbid Anxiety Inventory, a scale that correlates highly with autonomic indices of anxiety, found that 44%

of the adult population was anxious, while 31% could be classified as having a "sub-clinical neurosis" and 5% suffered from life-long anxiety states. There is little information on the prevalence of the specific syndromes described in D.S.M. III because of their recent general acceptance in psychiatric practice. One survey suggested that the lifetime expectancy of agoraphobia was approximately 5%.

As in the case of depression, most syndromes are found more commonly in women, apart from generalized anxiety states where the sex distribution appears to be approximately equal. There is good evidence that anxiety symptoms are found more frequently in patients attending physicians' offices and are seen particularly in certain types of practices, e.g., cardiology. Whether this implies a more specific relationship between anxiety and physical illness than common sense would expect, is unclear.

While the evidence relating incidence of anxiety to socioeconomic class is conflicting, an abundance of studies correlate changes in life stress with fluctuations in levels of anxiety. Furthermore, various reports suggest the importance of close interpersonal relationships in alleviating the effects of anxiety-inducing stress.

There are a paucity of well controlled long-term studies of outcome in anxiety disorders. However, most authorities agree that the outlook for sufferers of acute anxiety symptoms is good. The majority of these attacks are of brief duration and clear without sequelae. The course of the disorder in the patient with chronic symptoms is more unclear. Most anxiety syndromes tend to run a fluctuating course with relapses and remissions. Even in the more chronic disorders, however, the long-term outlook seems to be at least fair. In one study Wheeler, *et al* found that

TABLE	
Differential Diagnosis of Anxiety Disorders	
A. Other Psychiatric Disorders	
1. Affective disorder—depression	
2. Early organic brain syndrome	
3. Early schizophrenia	
B. Physical Illness or Chemical Agents	
1. Peptic ulcer disease	
2. Coronary artery disease and angina	
3. Asthma	
4. Hypoglycemia	
5. Caffeinism	
6. Amphetamine-like drugs	
7. Sympathomimetics in over-the-counter drugs	
8. Substance abuse and alcoholism—ingestion or withdrawal	
9. Hyperthyroidism	
10. Hypoparathyroidism	
11. Pheochromocytoma	
12. Carcinoid syndrome	
13. Acute intermittent porphyria	
14. CNS disease—neoplasm, epilepsy	

almost half of the patients had no discernable disability at the end of a 20-year period. Furthermore, somewhat surprisingly, there was no evidence of an increase in the incidence of so-called "psychosomatic" disorders in this population. By far the most frequent complication was substance abuse and/or alcoholism.

DIFFERENTIAL DIAGNOSIS

Symptoms of anxiety may occur in the course of almost any psychiatric syndrome and can frequently mask the underlying disorder. This is particularly common in depression where anxiety often co-exists or where the occurrence of agitation can be mistaken for anxiety. Surveys of hospital practices suggest that the tendency in these depressed patients is for the clinician to prescribe minor tranquilizers rather than antidepressants. This is particularly unfortunate as the appropriate treatment of depression

is generally effective in improving both the symptoms of anxiety and depression, whereas failure to treat the depression can be life threatening. By and large, minor tranquilizers are ineffective in the treatment of depression. Accurate diagnosis depends upon the elicitation of the classical features of depression by a careful history and mental status examination.

Anxiety may be a prominent feature in patients suffering from organic brain disorder, particularly early in its development and also can occur in schizophrenic patients, especially in their pre-psychotic or early psychotic stages. Again, diagnosis depends upon the careful collection of historical and mental status data by the clinician.

Errors in diagnosis between physical illnesses and anxiety disorders can occur in two ways. Some physical illnesses have signs and symptoms in common with anxiety. Perhaps the best example of this is hy-

perthyroidism, where the patient may appear apprehensive, have moist palms, tachycardia and diarrhea. On the other hand, patients with an anxiety disorder may have symptoms that make the physician suspect a physical illness, e.g., tightness in the chest and tachycardia suggestive of myocardial infarction. In addition, many drugs and chemical agents also produce anxiety-like effects when ingested. *The accompanying table* lists the more common illnesses and drugs where mistakes in diagnosis are likely to occur.

Unfortunately, the illnesses and agents involved are too diverse to allow for any simple routine screening examination. Nor can the distinction be made by mental status examination alone. Correct diagnosis requires a knowledge of the clinical features of those disorders most likely to produce anxiety symptoms together with an ability to undertake appropriate diagnostic procedures for each disorder. Not infrequently, this places the physician in a dilemma. He does not wish to subject the potentially anxious patient to unnecessary investigations, but also he does not want to miss a treatable condition. Continuity of care can assume great importance. Every effort should be made to ensure that, following a careful examination, the anxious patient does not go "doctor shopping" and have the same series of procedures repeated again and again.

TREATMENT

The treatment of anxiety disorders poses certain problems for physicians, psychiatrists and non-psychiatrists alike. The major difficulty rests in the key role anxiety plays in psychic organization and structure. As mentioned previously, anxiety can be conceived of as the psychic equivalent of pain. It's a warning of impending danger. As such, the ability to generate anxiety

is of great importance to the organism. At what point then is the physician justified in intervening to try to alleviate the symptoms? The careful delineation of the clearly pathological anxiety-related syndromes as outlined in D.S.M. III will be of considerable assistance in making this decision.

Furthermore, anxiety acts not only as a warning device, but it—or to be more precise, anxiety reduction—is one of the most powerful motivators for behavioral change in humans. Premature reduction of anxiety can, therefore, retard alterations in life style that would be of considerable benefit to the patient. At the same time any instrument which is a powerful anxiety reducer will inevitably lead to problems with psychological dependence. As has already been mentioned, substance abuse and alcoholism are the major complications seen in anxious patients. All present anxiolytic prescription drugs produce psychological dependence.

As few long-term studies in the life history of anxiety disorders have been done, the assessment of benefit of treatment is difficult. Most acute syndromes subside without intervention.

There are some general guidelines that should be used in the pharmacologic treatment of anxiety disorders. Most of the presently available minor tranquilizers are potent anxiety reducing agents, at least in the initial stages. The choice of drugs, therefore, depends upon other considerations. Because of the problems of drug abuse, medication should be used only for a limited time. The minor tranquilizers are most effective in the treatment of acute anxiety. Their effectiveness in chronic anxiety states is less well documented. They are probably least effective in that class of disorders termed "problems of living." Psychosocial intervention should be attempted concurrently with the prescription

of medication or should immediately follow the acute period.

Benzodiazepines offer two advantages over other drugs. They have a high therapeutic-to-toxic ratio, so the risk of fatal overdosage with them is smaller. They also are less likely to cause physiologic dependency than the barbiturates and related sedatives. Physiologic dependence, however, can occur after chronic ingestion of high doses, and withdrawal symptoms have been reported after abrupt discontinuation of the drug. In addition, benzodiazepines do not significantly stimulate hepatic microsomal enzymes. The most common side effects associated with benzodiazepine ingestion are drowsiness, ataxia, dizziness, vertigo and paradoxical excitement. Their sedating effects can impair skills that require concentration and this presents a risk for patients driving motor vehicles or working in hazardous surroundings. Benzodiazepines potentiate the action of other central nervous system depressants and, when taken in combination with ethanol or barbiturates, may cause fatal respiratory depression. Elderly patients appear to be particularly vulnerable to the side effects of benzodiazepines.

Chlordiazepoxide, diazepam and clorazepate produce one or more active metabolites in the body and all have relatively long half-lives. Daily administration of these drugs usually results in steady state levels in four to six days. Thus, after the second or third day of treatment only one single dose per day should be prescribed. The practice of prescribing benzodiazepines several times a day should be avoided as it can result in drug accumulation with production of unnecessary side effects. Oxazepam has no significant active metabolites and has, therefore, a shorter half-life.

The propanediols, e.g., meprobamate and tybamate, are less frequently used in recent years.

Unlike the benzodiazepines, these drugs have a narrow margin between the therapeutic and lethal doses, and fatal overdoses do occur. In addition, meprobamate is associated with significant physical dependence. Tolerance can develop rapidly, and profound withdrawal reactions can occur.

Sedative antihistamines such as Vistaril® and Atarax®, may be of special value in the treatment of anxiety-related skin conditions. Since their side effects, such as visual disturbances and dry mouth, provide intrinsic limitations against escalation of dosages, they are reasonable anti-anxiety agents for individuals who have demonstrated tendencies to abuse psychoactive drugs. However, dose-response characteristics are sometimes unpredictable and tolerance can develop to their pharmacological effects.

Sedative antidepressants such as amitriptyline and doxepin are effective in certain patients who demonstrate both high levels of anxiety and clinical indications of depression. Their major side effects are due to their anticholinergic properties.

Although the barbiturates are the least expensive of the anti-anxiety agents, their use is strictly limited since they have a low therapeutic-to-toxic ratio, readily depress the respiratory centers and can lead to fatal accidents or intentional lethal overdose. They also produce physical dependency and induce hepatic microsomal enzymes, interfering with metabolism of certain other drugs such as Coumadin®.

Beta-adrenergic blocking agents such as propranolol seem to be effective in reducing at least the sympathetic discharge associated with anxiety. To date, propranolol has not been approved by the Food and Drug Administration for the routine treatment of anxiety, but might reasonably be used when anxiety is associated with a medical

condition for which their use is indicated. Some clinical studies have suggested that propranolol and related drugs (beta₁-receptor blockers) successfully prevent panic attacks and can be of therapeutic benefit to patients whose symptoms are primarily, if not exclusively, peripheral.

Imipramine may be of particular use in treatment of agoraphobia. This drug primarily suppresses the patient's acute panic attacks, which in many cases stop within a few days of the institution of drug therapy. Other tricyclics may be similarly effective. While tricyclic antidepressants have largely replaced MAO inhibitors in the treatment of unipolar depressions, there also has been a rekindling of interest in the latter for the treatment of atypical depressive disorders in which anxiety and phobic symptoms are prominent.

There are a number of trade preparations that combine an anti-anxiety drug with one or more other pharmacological agents. Since these combinations are often expensive and have the disadvantage of fixed ratios of ingredients, they are seldom preferable to the individual drugs prescribed separately.

SUMMARY

The physician's role in the treatment of patients who present with symptoms suggestive of anxiety disorders can be summarized as follows:

A careful examination should be conducted, which would include a physical, appropriate laboratory investigations, a thorough history and mental status. If the results of the examination warrant it, the patient should be reassured of the absence of serious physical illness and at the same time an explanation of the physiologic symptomatology associated with anxiety should be attempted.

While many environmental stressors precipitate anxiety, once the symptoms have started fear of serious illness plays an important role in the continuation of the problem. The physician should then attempt an evaluation of potential psychosocial stressors in the patient's life, including an interview with a close family member.

Following information gathering, reassurance, simple environmental manipulation and the judicious use of medications following the guidelines outlined above often will lead to symptom relief. The time spent by the physician in this careful collection of data may seem excessive, but it will probably save a considerable amount of time and energy for both patient and doctor in the future. If an anxiety disorder is more chronic and persistent, referral to a psychiatrist for further treatment should be made.

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Recognizing Poison Ivy and Related Plants in Indiana

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PERHAPS THE MOST neglected area in the treatment of poison ivy dermatitis is in teaching patients to recognize the plant. Most individuals are unable to pick out poison ivy during the winter. Many can't even identify it in its characteristic summer form, but are too embarrassed to admit this to others. Such patients are easily taught by using good colored pictures of poison ivy

or the plant itself. They not only do not object to the instruction, but commonly go home and find the plant! Not all poison ivy looks the same, so one would do well to learn the characteristics of these plants in the area where he lives and vacations.

Poison ivy, poison oak and poison sumac belong to the genus *Toxicodendron*.¹ In Indiana, there are three indigenous *Toxicodendrons*. Two are rare, except in very limited areas, but the common midwestern poison ivy, *Toxicodendron radicans* ssp. *negundo*, is everywhere about us. This plant grows as a climbing vine on trees and fence posts and prefers rich, fertile soil. Larger plants have aerial rootlets and are frequently surrounded by small sprouts bearing leaves with three leaflets. These come up from the root system of the larger vine a few feet away.

Toxicodendron radicans ssp. *negundo* has notched (lobed) leaflets (Fig. 1), but leaf morphology varies from one clone to another. Its name comes from the box elder tree, *Acer negundo*, which has similar leaves. Larger vines have aerial rootlets and typical U or V-shaped leaf scars. In Indiana, flowers appear typically during the last week of May or the first week in June. This may vary with an unusually cool or warm spring, or at the southern or the northern ends of

the state. The flowers are not obvious, but when one looks for them, they are relatively easy to see up close. Blooms on the male plants have a very fragrant odor. Many different insects pollinate poison ivy, and honey bees make a non-toxic honey from its nectar.

With a little practice, it is rather



FIGURE 1

Toxicodendron radicans ssp. *negundo*. Leaflet morphology varies, but prominent lobing is common.



FIGURE 2

Toxicodendron rydbergii, a dwarf species with spoon-shaped leaflets, can be found in the Dunes region.



FIGURE 3

Toxicodendron vernix (poison sumac). Leaves have 7-13 leaflets that arise above the horizontal like "rabbit ears."

easy to recognize the climbing vine with three leaflets per leaf. The two lateral leaflets are often shaped like a pair of mittens with the palms upward. The symmetrical middle leaflet is supported by a much longer stalk (petiolule) which is definitely hairy on close examination. In the late spring, the light green leaves look tender when they first appear, but they often have a waxy, rumpled surface in the summer sun. Tiny new leaflets are reddish and have more regular margins but assume more characteristic color and shape as they mature.

The fruit is borne on a doubly-branched structure called a panicle, which arises under the leaf stalk (petiole). The smooth, non-hairy fruit is green early, but turns tan or dun at maturity. During winter, the off-white layer is lost, exposing a chalk-white layer with black striations.

Poison ivy is one of the first

plants to change color in the autumn, producing a beautiful display of red leaves on trees with green foliage, and it has even been planted for this purpose in other countries. In the early fall, this trait can be used to advantage in finding hidden poison ivy. Sprouts camouflaged in a hedge all summer suddenly stand out, making recognition easy.

Rydberg's poison ivy, *Toxicodendron rydbergii*, is a dwarf shrub seldom more than three feet tall in Indiana (Fig. 2). It is not nearly so dramatic in appearance as the larger *T. radicans* ssp. *negundo*. It is indigenous to the northern tier of states and Canada, being the most common variety north of the 44th parallel, but in this state, *T. rydbergii* is limited to a narrow band along Lake Michigan and perhaps Lake Maxinkuckee. Years ago, it was collected near Culver, but one of us (JDG) has been unable to find it there recently. It survives in the sandy soils of these regions where it is frequently associated with bracken fern and species of pine. *Toxicodendron rydbergii* differs from *T. radicans* in its small size, rather broad, concave leaflets, upright branches, and tendency for leaves to arise toward the top of the plant forming a pseudo-whirled appearance.

While native to Indiana, poison sumac, *Toxicodendron vernix*, has never been common here and is even less frequently found today. It grows in swampy areas and especially in peat bogs. Its seven to 13 leaflets with their smooth edges and pointed tips arise at an angle above the horizontal giving them the appearance of rabbit ears (Fig. 3). Veins in the leaflets are prominent, especially on the under surface. Female plants of this taxon can be recognized in the winter by their fruiting structure, an elongated panicle (Fig. 4) and the white fruit which often remains in the spring.



FIGURE 4

Poison sumac. Fruit-bearing panicles from the current season and empty ones from the previous year.

The benign species of sumac have fruiting structures that arise at the end of a branch rather than in an axillary position and form a conical structure bearing reddish or reddish-purple fruit at maturity. Leaflets of staghorn sumac, *Rhus typhina*, and smooth sumac, *Rhus glabra*, have finely toothed (serrated) edges and are greater in number than poison sumac. The leaflets of shining (winged) sumac are borne on a winged rachis.

Poison ivy and its toxic relatives have a poisonous oleoresin which oxidizes rapidly on exposure to the air. If one breaks the leaf or the bark, this substance is released from the plant and quickly oxidizes and polymerizes into a shiny lacquer-like deposit. Such black spots where the plant has been damaged should make one suspicious that he is confronted with a *Toxicodendron*.

Plants often confused with poison ivy include the box elder, *Acer*

negundo, Virginia creeper, *Parthenocissus quinquefolia* and aromatic sumac, *Rhus aromatica* and *R. trilobata*. The leaves of box elder arise opposite each other, a frequent character of the maple family of which it is a member. The fruits are winged very much like other maple fruits, and leaflets will frequently number more than three. Larger plants of box elder are obviously trees rather than vines and they do not form aerial rootlets.

Virginia creeper or five-leaved (sic) ivy frequents the same territory as poison ivy. The number of leaflets and their serrated margins help in identification. One would do well to look before grabbing even this plant since it is not uncommon to see poison ivy growing along with it on the same tree or utility pole.

Aromatic sumac, *Rhus aromatica*, also has three leaflets to a leaf.

However, these are rather different in shape than our form of poison ivy. They do resemble those of poison oak, which is not found in Indiana. The lateral leaflets of *Rhus aromatica* arise directly from the stem or very nearly so, and the fruit is found early in the season borne on a spindle-shaped spike. The name *aromatica* comes from a most unpleasant odor emitted when the plant is bruised or broken. This plant has been reported in the sandy soil around Lake Michigan and on rocky cliffs and bluffs near streams in other parts of the state.

Poison ivy is so common in Indiana that every Hoosier should learn to identify it. The treatment of poison ivy dermatitis was outlined in a previous publication in this journal.² Avoidance of trouble, however, is far better than the treatment of it.

SUMMARY

Three *Toxicodendron* species are found in Indiana. Two of these are only found in specific areas, but the midwestern form of poison ivy is extremely common and difficult to avoid. With practice and proper attention to morphological features, poison ivy is relatively easy to recognize even during the winter months. Some of the more important characteristics are summarized in the article and a plea is made for patient education as a means of preventing the skin eruption.

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Axillary Vein Thrombosis

The subject of axillary vein thrombosis was discussed during the Peripheral Vascular Conference conducted in January 1980 at St. Vincent Hospital, Indianapolis.

CASE PRESENTATION by A. L. Gardner, M.D.

A 21-year-old man came to the emergency room at St. Vincent Hospital in the early morning of Dec. 19, 1979, with swelling of the entire right arm.

He had not been aware of difficulty. He had been delivering pharmaceuticals to nursing homes and was noted by a nurse to have a swollen right arm. He had no complaint of pain. He had been aware that, while shaving, he could not bend his elbow as before. He gave no history of trauma but had exerted himself while trying to push a car out of an intersection several days before. He had noticed no pain in his arms or shoulder while pushing the car.

His past history was not remarkable. He denied the use of drugs. He specifically denied weight loss. His family history was non-contributory. On physical examination, his blood pressure was within normal range. There was no adenopathy or tenderness. The right arm, shoulder, and forearm were swollen and measured about 1½ times the circumference of the left upper extremity. The entire arm had a slightly bluish discoloration throughout. There were some prominent veins in the right axillary fold. The remainder of the examination was within normal limits.

Impression: Axillary vein thrombosis.

The course: The patient was treated with bed rest, elevation, and anticoagulation. He was encouraged to move his hand. There was clearing of the edema, but persistence of the collateral veins. He was released on anticoagulation with Coumadin and told to avoid contact sports. The patient was present and examination revealed some swelling.

Discussion: This is an infrequently encountered condition. It seems to be more common in young men and has been observed in workmen after prolonged tension while opening a sewer valve, for instance. A young man sitting at a bar for a long time on a Friday evening awoke the next morning to find his arm swollen.

Geza de Takats, in his book, *Vascular Surgery*, made the following observations:

"This condition is usually of sudden onset following violent unaccustomed exercise, affecting the right upper extremity more often than the left. There is, however, a form which appears gradually overnight and first manifests itself on arising. In our personal experience we have seen axillary thrombosis occur after cranking an old Ford, after grinding spark plugs, after a strenuous swimming match, after a

basketball game, and after washing windows with elevation and abduction of the arm.

"The mechanism of this sudden venous occlusion is unclear. It is likely that several different mechanisms may be at play. Compression of the vein between the clavicle and the first rib, pressure on the vein by pectoralis minor, by the costocoracoid ligament, by the subclavius muscle, and by the subscapularis and strangulation of the vein by an abnormally placed nerve, have all been suggested.

"The diagnosis of axillary thrombosis can hardly be missed when the sudden edema after effort, the purplish blue hand with maintained pulsations, and the characteristic collateral circulation are taken into account. When undiagnosed, untreated or indifferently treated, there remains a permanent edema with a feeling of tingling, heaviness, and cold sensitivity. Use of the arm for heavy or steady work will bring on pain with visible increase in venous pressure."

Dr. de Takats advocated a sympathetic block, followed by elevation and anti-coagulation and vigorous early treatment.

CASE PRESENTATION by Malcolm B. Herring, M.D.

A 22-year-old woman softball pitcher presented approximately one month following an episode of

sudden right arm swelling. She had some persistent swelling, although most of the swelling had disappeared. She complained of tingling in her arm when abducting her arm more than 30 or 40 degrees. In fact, a bruit was audible over the axillary artery and the radial pulse dampened when the arm was abducted more than 30 degrees. Further abduction resulted in loss of the bruit and loss of the pulse altogether.

Many patients who have venous thrombosis have problems related to the thoracic outlet. Yet most of these patients do not require surgical intervention of the thoracic outlet because the damage to the venous system has already occurred at the time of their evaluation. However, on occasion, patients will have involvement of the brachial plexus or axillary artery as the structures pass through the same compressed thoracic outlet.

An excellent anatomic study of the anomalies associated with the thoracic outlet syndrome was assembled by Dr. David Roos and published in 1976. He identified, both at surgery and autopsy, seven types of thoracic obstruction:

Type I is characterized by a tough, fibrous, ligament attached to the anterior tip of an incomplete cervical rib that stops short of a bony connection to the first thoracic rib. The ligamentous attachment is, of course, not visible on the radiograms.

Type II anomaly is the development of a fibrous band between the first rib and an extended transverse process of the seventh cervical vertebra. This can be identified on plain radiograms by the fact that the transverse process of the eighth cervical vertebra is longer than the transverse process of the first thoracic vertebra.

Type III is the most common and represents a tight muscular

band originating on the anterior and lateral surface of the neck of the first thoracic rib and passing straight across the thoracic outlet inside the posterior curve of the rib to attach again just behind the scalene tubercle.

Type IV represents an anomalous connection between the anterior and middle scalenous muscles, either forming a muscle sling or loop under the inferior trunk of the brachial plexus and the subclavian artery.

Type V is a small ribbon-shaped scalenus minimus muscle arising from the transverse process of the lower cervical spine, most commonly the sixth and seventh cervical vertebrae, and passing obliquely to attach to the first rib between the subclavian artery and brachial plexus.

Type VI anomaly represents the scalenus minimus muscle attaching to the cupola of the pleura beneath or medial to the first thoracic rib.

Type VII is the least common anomaly and is represented by a tight fibrous muscular band originating on the anterior surface of the scalenus anticus passing anterior beneath the subclavian vein and attaching to the costoclavicular junction of the first rib under the head of the clavicle, causing an abnormal kink in the vein.

It is apparent from this list of anomalies that certain anomalies may affect selectively the neurovascular structures as they exit the thoracic outlet. The detection of these compressions is little aided by the use of electromyography and nerve conduction test. Similarly, little is to be gained by arteriography unless there is some evidence of aneurysm formation, dissection of the artery, or distal embolization.

The compression of the artery is best detected by physical examination, in which the arm is placed

through a number of positions designed to provoke compression of the artery, these being the abducted position, the military posturing with inspiration and turning of the head, both away from the suspected lesion and toward the suspected lesion.

Dr. Roos has suggested additional signs, which include tenderness over the brachial plexus and muscular weakness, especially with the grip and triceps muscles and interosseus muscles of the hand, and hypoaesthesia to touch and pin prick. Finally, he relies on an elevated arm exercise test. During this test the patient abducts the arms and hold the hands above the head while alternately opening and closing the fists at a moderate speed for approximately three minutes. The patient who is able to accomplish this is very unlikely to have a thoracic outlet compression by Dr. Roos' criteria.

Given the nature of the anatomic obstruction, surgical relief of the thoracic outlet compression is best afforded by a first rib resection. On reviewing the various types of anatomic abnormalities, the removal of the first thoracic rib and any cervical rib will relieve all of the types of compression which were mentioned.

Dr. Gardner: As Dr. Herring mentioned, thoracic outlet procedures are rarely necessary in the treatment of axillary vein thrombosis.

Sir James Paget first described this clinical entity in 1875. A good review of the problem was published in the British Journal of Surgery by E. S. R. Hughes who suggested the eponym Paget-Schrotter syndrome. (Schrotter's description was in 1884.)

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Severe Hypertension Complicated by Bilateral Renal Artery Stenosis, Abdominal Aortic Aneurysm, and Renal Cell Carcinoma: Surgical Management

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RENAL ARTERY BYPASS surgery is occasionally performed for hypertension related to renal artery stenosis and rarely performed to preserve renal parenchyma.

The usual procedure for a renal cell carcinoma is nephrectomy. Rarely is a partial nephrectomy performed in an attempt to preserve renal parenchyma.

This case report is on a patient who required both these techniques to treat a complicated clinical problem.

CASE REPORT

A 57-year-old white woman had been hypertensive, under reasonably good control with medication, for approximately 12 years. Four weeks before admission, this control became more difficult and she began experiencing shortness of breath. She presented to Methodist Hospital's emergency room the morning of Oct. 15, 1977, in acute pulmonary edema manifested by labored respirations, cyanosis, lethargy, and a blood pressure of 250/



FIGURE 1

IVP at 5 minutes shows minimal calyceal filling on the left with a small left kidney.

120. EKG showed left ventricular hypertrophy and an enlarged left atrium.

She was admitted and treated with a variety of anti-hypertensive drugs including Ser-Ap-Es®, reserpine, Apresoline®, Raudixin®, Aldomet®, Lanoxin®, Lasix®, and Valium®.

Her condition improved but her blood pressure consistently remained in the 170 to 190 over 90 to 100 range and appropriate additional studies were obtained.

A lung scan was normal. An IVP showed the right kidney measured 12 cm. compared to the left which measured 9.5 to 10 cm. with delayed calyceal filling (Figure 1). A

renogram and scan demonstrated normal function on the right with increased activity in the right superior pole and abnormal tubular function in the smaller left kidney, accounting for only 20% of the total perfusion. Renal ultrasound showed dense echoes in the right upper renal pole.

Aortography revealed an abdominal aortic aneurysm with a mural thrombus in the wall, stenosis of the iliac arteries with ectasia of the distal left common iliac artery, severe stenosis of both renal arteries with the lumen on the left measuring only 1 mm. and the right stenosis, occurring at the renal artery origin, associated with a large aortic plaque. Additionally, a 4 cm. vascular tumor was noted laterally in the right upper renal pole (Figure 2).

Additional physical examination revealed abdominal epigastric bruits with good femoral, popliteal, dorsalis pedis and posterior tibial pulses bilaterally. Supine peripheral renins were elevated at 12.1 mgm. per ml. per hr. (normals .8 to 1.2), and standing 13.4 (normal 1.3 to 2.2). Twenty-four hour urine creatinine clearance was 82 cc. per minute with a serum creatinine of 1.2. Serum potassium on admission was 2.7 and this was corrected. A serum aldosterone was normal at 26.8. Urine culture was negative. A T-4 was normal at 6.9. Cardiac enzymes and diurnal cortisol levels were normal.

From Methodist Hospital of Indiana, Inc., 1604 N. Capitol Ave., Indianapolis 46206.

Supported in part by a grant from the Shewalter Fund.

Acknowledgement: William Wise, M.D., for referral of the patient.

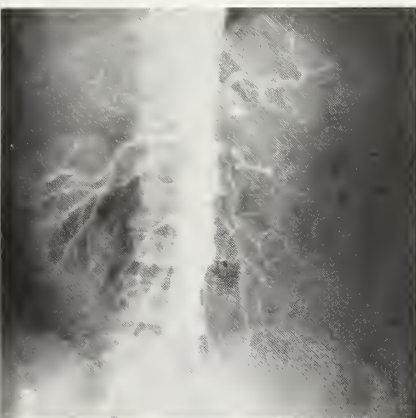


FIGURE 2

Aortogram depicts severe bilateral renal artery stenosis particularly severe on the left. Severe aorto-iliac arteriosclerosis also is evident. A 4 cm. spherical vascular tumor can be seen at the superior pole of the right kidney.

After considerable discussion, it was felt that continued medical treatment would be ineffective, that staged surgical correction of her many problems might well prove to be technically very difficult if not impossible, and that preservation of as much functioning renal tissue as possible was imperative. A decision was reached to try, in one operative procedure, to resect the aneurysm with aortic to bilateral femoral grafts, to do bilateral renal artery grafts, and to do a partial right nephrectomy. The complexity and high risk of the surgery was explained in detail to the patient and family and was accepted.

On Nov. 1, 1977, a resection of the abdominal aortic aneurysm with aortic to bilateral femoral grafts, bilateral bypass grafts to the renal arteries, a partial right upper pole nephrectomy and an incidental splenectomy was performed. The operative time was 9 hours and 15 minutes. The patient received 10 units of blood during surgery. The renal pedicle was clamped for 40 minutes. Blood pressure was 200/

100 at the end of the procedure.

Her postoperative course was remarkably uncomplicated except for some initial gross hematuria, which cleared, and slight mental confusion, which disappeared. She never displayed more than mild azotemia and, at the time of discharge from the hospital, her creatinine was 2.2, and BUN 47. A postoperative renogram and scan showed the right kidney measuring 11 cm. and the left 10.5, with 65% of the activity occurring on the right and 35% on the left. There was some tubular dysfunction noted on the right. An aortogram on Nov. 14, 1977 (Figure 3) showed good peripheral run-off with patient aortic iliac grafts, patent bilateral renal artery grafts and no evidence of residual carcinoma. The renal tumor was a clear cell carcinoma, which was well circumscribed and showed no blood vessel invasion. Adjacent renal parenchyma, although compressed, showed no evidence of tumor involvement. She was discharged two weeks postoperatively on Lanoxin®, Lasix®, Inderal®, and Stelazine® with a blood pressure in the 130 to 140 over 80 to 90 range.



FIGURE 4

Postoperative IVP at 5 minutes shows good equal function bilaterally with absence of upper half of right kidney.

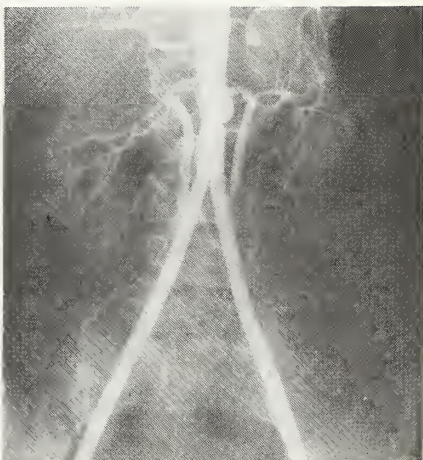


FIGURE 3

Aortogram postoperative shows functioning aorto-iliac grafts with functioning grafts to both renal arteries.

The patient has been followed at periodic intervals and maintains normal renal function with mild elevation of her blood pressure in the 160/80 to 90 range. Present medications include: Zaroxolyn® 5 mg. daily, Raudixin® 100 mg. t.i.d., Lanoxin® every other day, and Phenobarbital® p.r.n., at bedtime. A recent chest x-ray showed normal cardiac size and no evidence of metastatic disease. A recent intravenous pyelogram showed bilateral prompt function with comparable renal size and minimal post surgical scarring in the right superior pole (Figure 4).

SUMMARY

A 57-year-old patient with an abdominal aortic aneurysm, bilateral renal artery stenosis, and a renal cell carcinoma in her better kidney had a resection of the abdominal aortic aneurysm with aortic to bilateral femoral grafting, bilateral renal grafts, and heminephrectomy of her right kidney to remove the renal carcinoma. She has done well since surgery.

What appears to be too much surgery may be just what the patient needs.

Humor

To Clone Or Not To Clone

ALISTER CAO BHAIN

There has been, the past few years, an amount of comment in both the scientific literature and the lay press concerning cloning. Some have expressed their greatest concern as to the possibility of cloning a human being, almost to the point of an uproar because of the uncertainty of the result.

I hope it is not too late to point out that such a clone has already been done and that the results are well known—so well known, in fact, that it is another case of “The Invisible Man” or of the “Purloined Letter” and has likewise been overlooked.

The result was so totally different from what might scientifically be expected that it should deter anyone from repeating the experiment—namely, the product of this cloning turned out to be of a different sex. Startling? Yes, but that’s the way it was.

Thereupon, the Experimenter, being wiser than we, desisted. But the fat was in the fire and we now have *Homo sapiens* who has spread far and wide entirely out of control.

If the cloning of a man, Adam, with 46 chromosomes including xy, produced Eve, also with 46 chromosomes but with xx and no y, all this in a special secluded location under strictly controlled laboratory conditions, and the result was the human race, how can we dare try this experiment again? As the little neighbor girl used to say to Fibber McGee, “How could you, huh? How could you?”

I propose that this be called to the attention of the geneticists, together with the dictum that until the original cloning experiment is fully and satisfactorily explained, such experiments upon any member of the human race, male or female, be strictly interdicted. If, in fine, such experiment is to be attempted, the science fiction writers should prepare the protocol—with shudders.

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CONTRAINDICATIONS Use in Newborn or Premature Infants. This drug should not be used in newborn or premature infants

Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section)

WARNINGS Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction

Use in Children: In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.)

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older): Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils, flushing, and gastrointestinal symptoms) may also occur

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and 1/2 isotonic saline is the lavage solution of choice

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content

Stimulants should not be used

Vasopressors may be used to treat hypotension.

FEBRUARY 1977

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RANDOLPH or KATHY SCANLON.

Treatment of Anxiety States

CONTINUED FROM PAGES 300-305

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223.**

- The physiologic response to fear is usually:
 - Parasympathetic only
 - Sympathetic only
 - Mixed, with sympathetic dominance
 - Mixed, with parasympathetic dominance
- In agoraphobia:
 - Depressive disorders seldom occur.
 - Tricyclic antidepressants may be a useful treatment.
 - The individual is often incapacitated at home as well as when leaving the home environment.
 - Panic attacks are not associated with this disorder.
- In phobias:
 - The fear producing stimulus is known to be dangerous.
 - The fear producing stimulus is known to be harmless.
 - Agoraphobia is the least incapacitating.
 - Simple phobias rarely persist into adulthood.
- Panic attacks:
 - Are usually associated with marked physical exertion or life-threatening situations.
 - Are often associated with feelings of impending doom.
 - Often last for many hours.
 - Are not associated with "free floating" anxiety between attacks.
- Generalized anxiety disorders:
 - Are rarely confused with physiologic disorders.
 - Are manifested by chronic, autonomic hyperactivity.
 - Are rarely associated with depressive symptoms.
 - Rarely begin before the age of 30.
- Anxiety disorders are:
 - Often self-treated with alcohol.
 - Less common than depressive disorders.
 - Responsive to chronic benzodiazepine administration.
 - Not responsive to psychosocial therapies.
- Benzodiazepines:
 - Are clearly superior to placebo in treatment of chronic anxiety.
 - Are useful in prevention of panic attacks.
 - Have a low therapeutic-to-toxic ratio.
 - Are associated with physical dependence when used chronically at high doses.
- True statements about benzodiazepines include:
 - Daily administration results in steady-state levels in 2-3 weeks.
 - They should routinely be prescribed on a T.I.D. or Q.I.D. basis.
 - After the second day of treatment, a single dose at bedtime may be used.
 - Elderly patients often require higher doses.
- Which of the following statements is incorrect?
 - Meprobamate is associated with physical dependence and withdrawal reactions.
 - Barbiturates are the least expensive anxiolytic agents.
 - Inderal® is approved by the F.D.A. for routine treatment of anxiety.
 - Sedative antihistamines, Vistaril® and Atarax®, may be of special value in treatment of anxiety related skin conditions.
- All of the following are correct except: The prevalence rate of anxiety disorder is:
 - Higher in men than women.
 - Higher in patients attending cardiologists.
 - Approximately 5% in the general population.
 - Directly associated with life stressors.

Answers to the CME quiz that appeared in the April 1980 issue of THE JOURNAL: "Outpatient Treatment of Asthma in Children," by Peter H. Scott, M.D.

- | | |
|------|-------|
| 1. a | 6. c |
| 2. d | 7. a |
| 3. b | 8. b |
| 4. b | 9. c |
| 5. d | 10. d |

Answer sheet for Quiz: (Anxiety States)

- | | |
|------------|-------------|
| 1. a b c d | 6. a b c d |
| 2. a b c d | 7. a b c d |
| 3. a b c d | 8. a b c d |
| 4. a b c d | 9. a b c d |
| 5. a b c d | 10. a b c d |

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this month's quiz, send your completed, signed application before June 10, 1980, to the address appearing at the top of this page.



Physician Community Service Award

The Indiana State Medical Association is
now actively seeking nominations for the 1980 Physician
Community Service Award.

With this award, we wish to recognize and honor individual
physicians who have contributed outstanding
and meritorious service
to their local communities and to the state in
voluntary service.

You can help.

If you know of a fellow physician whose community
service you believe should be recognized, contact your
county medical society.

Nominations must be submitted to ISMA by the county
medical society of which the nominee is a member.

Won't you do your part in honoring
deserving fellow physicians?

Nominations deadline: June 30, 1980.

Court Action

Indiana Malpractice Act Applicable to Federal Diversity Malpractice Claims

The Indiana Medical Malpractice Act of 1975, which required that medical malpractice claims be submitted to a medical review panel before filing suit, applied to a suit filed in federal court, a federal appellate court in Indiana has ruled.

A malpractice suit was filed in a federal trial court in Indiana. The claimant was a non-resident of Indiana suing an Indiana hospital and other persons. The defendants moved to dismiss the suit because the claimant had not complied with the Medical Malpractice Act. A trial court dismissed the suit on the ground that the Act applied

in federal court in actions based on diversity of jurisdiction.

On appeal, the court affirmed the decision. The law to be applied in diversity suits was the law of the state, the court said. There was nothing in the Act that prevented its application in federal court. Requiring submission of the claim to a medical review panel would not detract from the independence of the federal judicial system nor disrupt the federal system of allocating functions between judge and jury, the appellate court said. — *Hines v. Elkhart General Hospital*, 603 F.2d 646 (C.A.7, Ind., Aug. 3, 1979)

Editor's Note: A prior decision in this case was reported in THE JOURNAL, Vol. 72, No. 9, p. 669, September 1979.

Courtesy of THE CITATION, Feb. 1, 1980.

Organized Medicine Is a Bargain . . .

CONTINUED FROM PAGE 287

So far as the CMA is concerned, much of what I've said applies to that organization. Their costs are also dictated largely by inflation and increased demands of members.

The AMA—which is the only voice medicine has on a national level—is holding the line against some of the most vicious and dedicated attacks against the private practice of medicine. Court costs and legal fees, alone, involving lawsuits by and against chiropractors, the Federal Trade Commission, HEW and numerous other government and fringe agencies and organizations, cost hundreds of thousands—even millions—of dollars. Here again, the AMA is fighting these battles for *all* physicians: those who join, and those who don't pay dues.

In all, the "federation" of medicine (county, state, AMA) is the only viable choice a physician has today between him or her and those who believe private practice and fee for service should be abolished. Of course, there are other smaller groups who also stand up for our principles, but without the "federation," there would be no unified, strong and effective voice that represents all physicians at the local, state and national levels.

You say we should review our expenditures

and make the association more affordable for the individual physician. This has been done, in a lengthy and agonizing process, over a period of some months—and it is *each* summer and fall when LACMA's budget-making review is underway. One way we could reduce dues would be if *all* physicians in Los Angeles would join LACMA. As it is now, less than 10,000 physicians pay dues yet there are 3,000 or 4,000 additional physicians who are eligible. If they all joined, it would be possible to reduce everyone's dues.

In the absence of this as an immediate possibility—though we are actively recruiting new members—I should mention that membership in organized medicine is something a physician cannot afford *not* to hold. The \$920 bottom line on your dues statement (which in actual dollars, after tax deduction as a business expense, amounts to less than \$500 for the average physician) is a small amount to pay for sharing in the preservation of our profession. Many union members and those in less-respectable professions pay more than physicians to their unions or trade organizations.

I hope you will remain an active supporter of organized medicine. We need you, and all physicians, if we are to continue to protect and defend the profession and the patients we serve.

BOOK REVIEWS

Histology: A Color Atlas of Cytology, Histology and Microscopic Anatomy

2nd Edition by Frithjof Hammersen, M.D. Copyright 1980, Urban & Schwarzenberg, Baltimore. 235 pages, \$29.

This book will be of interest primarily to medical students and to a lesser extent to pathologists. It starts with a brief section on histologic techniques that will be helpful to the beginning histology student. Next there is a section on cytology using many electron micrographs. This will be of interest to older pathologists who have not had much exposure to electron microscopy in their training or their practice. Then follows the main portion of the book on the histology of the various organs and tissues.

With the exception of the electron micrographs, most of the illustrations are in color. All are extremely well done. Fifteen tables are present at the end of the book. These cover such things as the identification of different parts of the digestive tract, different lymphoid organs, or various types of fibers.

The book consists primarily of 499 illustrations, with a brief description of each. This is an excellent refer-

ence book for the histology student and provides a relatively painless way for any physician to review and update his knowledge of histology.

ELTON HEATON, M.D.
Madison
Pathology

The Low-Cholesterol Food Processor Cookbook

Suzanne S. Jones. Foreword by Kevin E. Conboy, M.D. Copyright 1980 by Suzanne S. Jones, Doubleday & Company, Inc., New York, N.Y. 10017. 210 pages, \$9.95.

This is a "must" cookbook if you want variety and taste even if you aren't on a restricted diet.

Dr. Conboy's foreword on the medical need for a low cholesterol, low sodium, or low fat diet cannot be improved.

I find Mrs. Jones' book a challenge, and it should make both patients and patients' families want to adhere to the special diets. I tried several recipes and found them delicious and simple to prepare.

An additional dividend with this cookbook is a quick course in the use of a Food Processor.

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Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvian balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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BOOK REVIEWS

Atlas of Topographical and Applied Human Anatomy

Vol. 1, Head and Neck, 2nd Edition. By Eduard Pernkopf, edited by Helmut Ferner, M.D. Copyright 1980, Urban & Schwarzenberg, Baltimore. 308 pages, \$98.

The first edition of this atlas appeared in 1963-64. This second revised edition incorporates new color plates, as well as new roentgenograms, reflecting the new techniques and requirements of modern medicine. The nomenclature used is based on *Nomina Anatomica* for the most part.

This large atlas is divided into the head, neck, vertebral canal and spinal cord, pharynx, and larynx. The quality of the illustrations is superb, with most in color. Labeling of the structures is clear and uncluttered. Considerable ingenuity has gone into the illustrations. For example, underlying structures such as the brain are portrayed in relation to the overlying skull and integument. The x-rays presented in conjunction with the colored plates should prove extremely useful. The atlas incorporates 231 full color and 108 black-and-white illustrations.

The volume is sturdily bound in cloth. The price appears modest considering the quality of this truly magnificent volume. It would appear to be especially useful for surgical and medical specialists whose work deals with the head and neck.

W. D. SNIVELY, JR., M.D.
Evansville
Internal Medicine

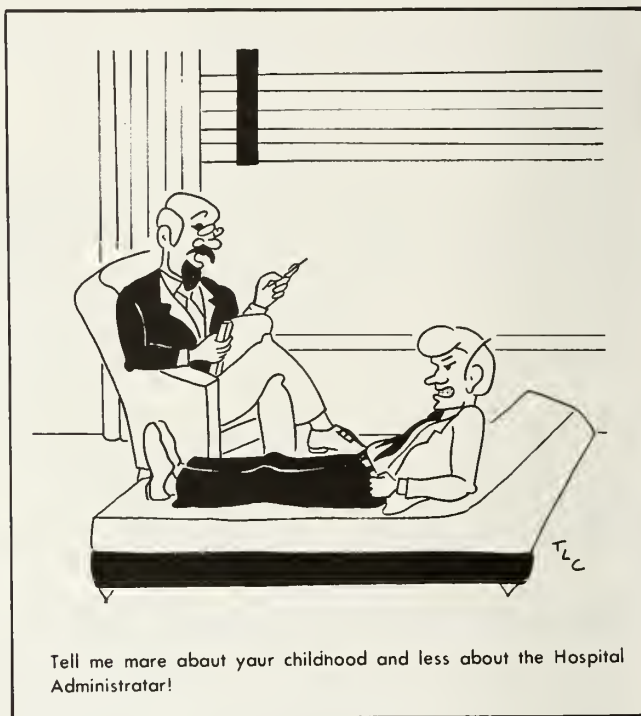
Current Medical Diagnosis and Treatment

Marcus A. Krupp, M.D. and Milton J. Chatton, M.D. Copyright 1980, Lange Medical Publications, Los Altos, Calif. 1,076 pages plus index, \$19.

The 19th annual revision of this paperback textbook of medicine continues the same general format of earlier editions, and of most other medical texts.

As one might expect with yearly re-editings, it is extremely up-to-date; further, since it is so well referenced, it functions in some ways as a yearbook, providing easy access to the most recent literature on the topics it covers. The content of a yearbook, however, is determined by the content of the medical literature of the previous year, whereas this book's content is determined by one editor's goal. . . "(to provide) a useful desk reference on widely accepted techniques currently available for medical diagnosis and treatment."

There is nothing abstruse here, though there is very much that is new. The style of writing is terse, sometimes telegraphic, but the coverage is not superficial:



The chapter authors simply do not waste words or space.

Without the luxury of extra room to explain subtleties, the presentations are often dogmatic, and I easily found discussions with which I disagree more or less completely, but so it is with any dogma. More important is the fact that I could not find a chapter I thought poorly done. Most are good; several, such as Brophy's section on psychiatric disease (including pain, addiction, geriatrics, and death) and the new chapter on nutrition, long neglected in medical texts, are excellent.

The appendix contains information that fits nowhere else; in fact, it contains information I have not seen in a traditional medical text: medical recommendations for foreign travel, immunization schedules for children, and sections on interpreting and determining the validity of laboratory tests.

For whom is it written? Like Donne's bell, it is for all of us. The information, like the list of authors, is drawn from many medical and surgical specialties; it is basic and important, and is the nucleus of what every well informed physician should know. This book is designed and written well enough to be read and used frequently; furthermore, it is up-to-date, reliable and inexpensive. Buy it.

JAMES K. CONDON, M.D.
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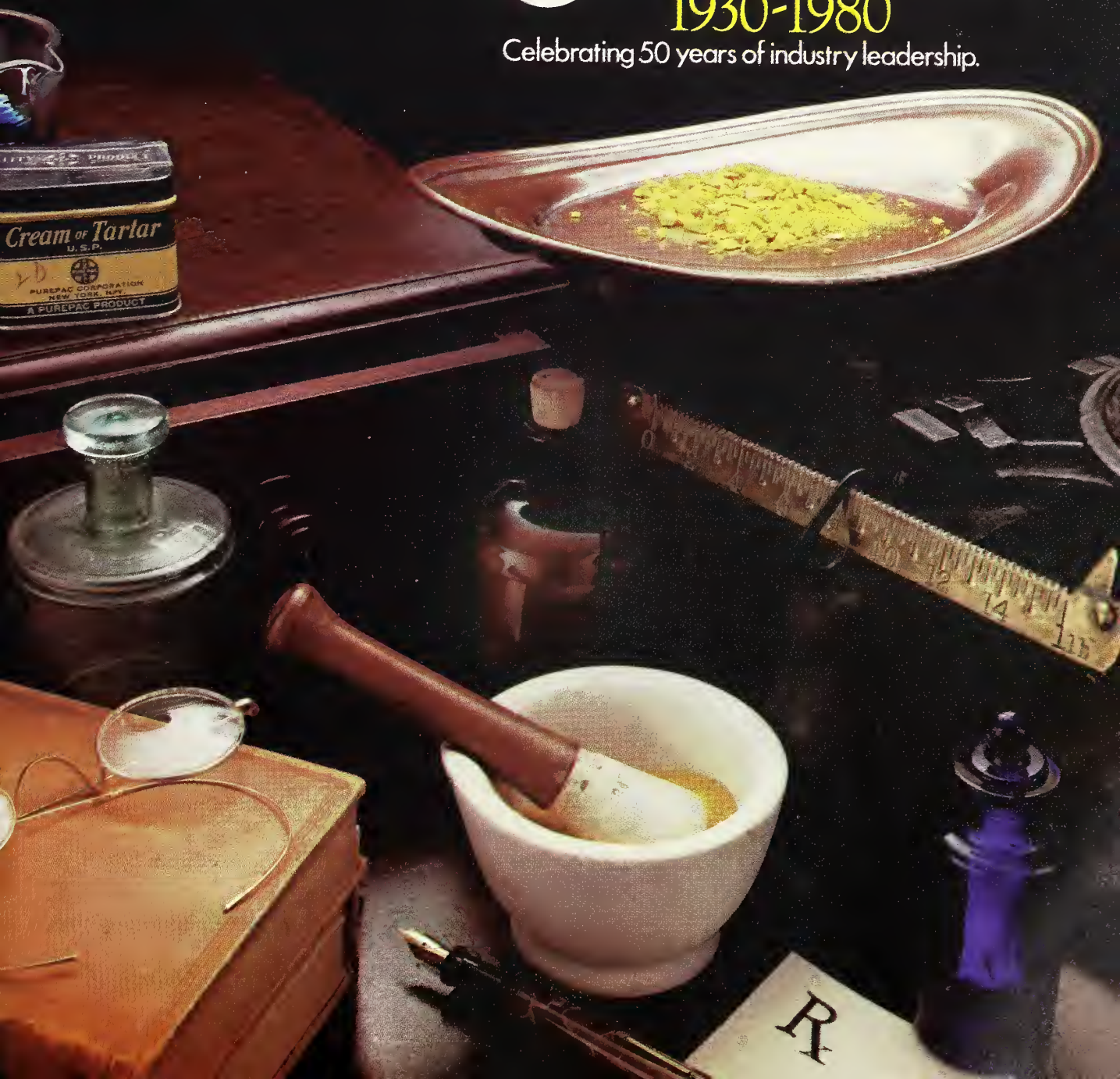
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for adjunctive therapy of duodenal ulcer* and irritable bowel syndrome*

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Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma, prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Bromide.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium[®] (chlordiazepoxide HCl/Roche) to known addicts.

tion-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression: suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug

and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.

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ASLM Plans Conference

The legal and ethical issues affecting the health care of critically and terminally ill patients will be explored during a two-day conference June 5-6 at the Radisson South Hotel in Minneapolis.

The conference is sponsored by the American Society of Law and Medicine, in cooperation with the Minnesota Hospital Association. Registration fee is \$130.

To register write to the Society at 520 Commonwealth Ave., Boston 02215. Hotel reservations may be made directly with the hotel at 45 S. Seventh St., Minneapolis 55402. Tel: (612) 835-7800.

'Exam Cram' Slated

The Indiana Academy of Family Physicians will conduct an "Exam Cram" on patient management problems June 27-29 at the Airport Holiday Inn, Indianapolis.

The course is designed to prepare family physicians and family practice residents for the American Board of Family Practice two-day recertification examination in July.

The fee for AAFP members is \$225, which includes syllabus, luncheons, coffee breaks, and a copy of Family Practice Assessment Program Pre-Test. For AAFP-member F.P. residents, the fee is \$65. For non-member residents, the fee is \$75 and, for non-member physicians, \$325.

Contact Jackie Schilling, IAFP, 4847 S. High School Road, Indianapolis 46241. Tel: (317) 856-3757.

Conference on Health Records

"Quality of Patient Care, Risk Management, and the Health Record" will be the subject of the 11th Annual Multidisciplinary Conference on Health Records, to be held at the Benjamin Franklin Hotel, Philadelphia, June 23-25.

Direct inquiries to William H. Kincaid, Executive Director, Association for Health Records, CWRU School of Medicine, Cleveland, Ohio 44106. Tel: (215) 229-9744.

Computers in Private Practice

"Choosing and Using a Computer in a Private Medical Practice" will be the subject of a two-day session to be conducted by University of Health Sciences/the Chicago Medical School at the Marriott O'Hare Hotel, Chicago, June 20-21. The tuition is \$212, which includes coffee breaks and two luncheons. The course carries 18 hours credit in Category 1.

Correspond with Ronnie Beth Bush, Ph.D., One Chapman Road, Burlington, Ill. 60109.

Negotiating Physician Compensation

"Compensation for Negotiating Physicians" will be the subject of a national conference in Washington, D.C. from Sunday evening, June 15 through Tuesday afternoon, June 17.

The conference will be held at Loew's L'Enfant Plaza for physicians, medical society executives and leaders, attorneys, hospital administrators, financial executives and consultants. John A. Norris, J.D., M.B.A., editor-in-chief of the AMERICAN JOURNAL OF LAW & MEDICINE, will be chairman.

Advance registration is required. The fee, which includes luncheon on both days and conference material, is \$250 for members of the AMA or the American Society of Law & Medicine, \$295 for non-members.

Send name, address and fee to American Society of Law & Medicine, 520 Commonwealth Ave., Boston, Mass. 02215. The L'Enfant Plaza Hotel has a specially priced block of rooms reserved. Reserve hotel rooms directly, (202) 484-1000.

Fiberoptic Bronchoscopy

"Fiberoptic Bronchoscopy: A Workshop" will be presented May 30-31 at the Hyatt Regency Hotel in Lexington, Ky.

For details, contact Frank R. Lemon, M.D., Continuing Education, College of Medicine, University of Kentucky, Lexington, Ky. 40536. Tel: (606) 233-5161.

Conference for Sex Educators

The Indiana University Institute for Sex Research announces its 1980 Conference for Sex Educators. The program will be held at the Poplars Research Center in Bloomington, July 25 to Aug. 1. This conference will concentrate on updating knowledge in various areas of sexuality curriculum, developing teaching strategies and sharing ideas with other professionals from throughout the country.

The program includes sessions on: Sexual Attitude Reassessment, Anthropological and Sociological Dimensions; Male and Female Sexuality; Sexuality and the Physical and Mental Impairments; Genitourinary and Reproductive Health; Sexually Transmitted Diseases; and Sexual Dysfunctions.

As an organization accredited for continuing medical education, the Indiana University School of Medicine designates this continuing medical activity as meeting the criteria for 60 credit hours in Category 1 of the AMA Physicians Recognition Award.

For enrollment information write before May 31, 1980 to Michael S. Aronoff, M.D., 600 N. Jordan Avenue, Bloomington, Ind. 47405.



THE INDIANA MEDICAL FOUNDATION, INC.
3935 North Meridian Street
Indianapolis 46208

A foundation for charitable, educational, and scientific purposes, organized by the ISMA as an endowment fund to support the educational mission of the Association and THE JOURNAL.

Bequests, legacies, devises, transfers or gifts to the Foundation or for its use are deductible for federal estate and gift tax purposes, in accordance with the Internal Revenue Code.

The Foundation is managed by a board of directors that comprises the members of the ISMS Executive Committee. At present, proceeds from the Foundation investments are awarded to THE JOURNAL to further the continuing medical education program.

Memorial contributions made to the Foundation in lieu of flowers will be acknowledged by the secretary in a letter to the family of the deceased.


*"for religious, charitable, scientific,
literary or educational purposes"*

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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mg. / mg. / mg.

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Additional indications: Replacement therapy. When androgen deficiency is the cause of: male climacteric / eunuchoidism, eunuchism / post-puberal cryptorchidism.



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AUXILIARY REPORT

Dorothy (Mrs. Herbert A.) Schiller
President, ISMA Auxiliary

Greetings, members of the Indiana State Medical Association!

I appreciate the opportunity to communicate with you via *THE JOURNAL*, and I thank you for allowing us to carry on this tradition.

This is my initial message to you. Those of you who take time away from your busy professional life to read this page will realize that a new Auxiliary year has been launched. This is a beginning—the beginning of a new decade, a new Auxiliary year, a new face and a new regime.

By the time you read this, the 36th House of Delegates will have been held in Evansville and the new Auxiliary officers installed for the coming year. It is with pleasure that I present to you the Executive Committee of the ISMA Auxiliary for 1980-81. *See the accompanying box.*

With our Executive Committee, together with the other dedicated and capable members of the board, we look forward to providing guidance to the county auxiliaries and to members at large.

A cluster workshop is scheduled for Wednesday, May 28, at the home of Mrs. Glenn W. Irwin, Jr., in Indianapolis. All county officers, chairmen and auxiliary members are urged to attend this informative session. Each state chairman will have materials, ideas, and helpful suggestions for her county counterpart.

Leadership skills will be emphasized during the workshop. Marge Smith of Fort Wayne, AMA-A North Central regional vice-president, will address the group, as will Dr. Nancy Roeske, an Indianapolis psychiatrist, who will discuss alcoholism in 8- to 12-year-old children. Dr. Roeske's talk is entitled "From Bottle to Bottle."

Will you help our first activity of the 1980-81 year by encouraging your spouse to attend the workshop

May 28? It'll be an interesting social gathering, as well as an educational journey.

I look forward to working with Dr. Arvine G. Popplewell, ISMA president, and Dr. Alvin J. Haley, president-elect. We offer them and you the continued support of the ISMA Auxiliary and renew our pledge to organized medicine "to support its activities, protect its reputation, and ever sustain its high ideals."

President.....	Mrs. Herbert A. Schiller (Dorothy), South Bend
President-elect.....	Mrs. Glenn W. Irwin, Jr. (Marianna), Indianapolis
First Vice-President.....	Mrs. Irvin H. Sonne, Jr. (Agnes), New Albany
Northern Area Vice-President ..	Mrs. Carlos Serna (Donna), Munster
Central Area Vice-President...	Mrs. Robert E. Wrenn (Anne), Bloomington
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Recording Secretary	Mrs. William L. Dixon (Pat), Vincennes
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NEWS NOTES

Agent Orange Not Guilty?

Veterans Administration chief Max Cleland recently testified before Congress in regard to Agent Orange and its use in Vietnam. He said, "Despite major efforts by many agencies and individuals it remains unclear" whether exposure to the herbicide used in Vietnam can cause "any long term effects on human health." He reported that harmful and even fatal effects may be produced by concentrated doses over a prolonged period on experimental animals. "Thus far, no human study has shown any evidence for a delayed syndrome of toxicity of any Agent Orange constituent encountered under accidental conditions."

Occupational Medicine Society

The Central Indiana Society of Occupational Medicine meets three times annually to discuss common problems or clinical cases related to occupational medicine. At its most recent meeting, in March, Dr. James L. Strickland of the Hand Rehabilitation Center of Indiana discussed treatment of commonly occurring hand injuries.

For further information, contact Brock Weisenberger, M.D., 605 Cottage Ave., Columbus, Ind. 47201.

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Generic Drug Laws Could Result in Lawsuits

Laws intended to save patients money by allowing pharmacists to substitute lower-priced drugs for brand-name drugs prescribed by physicians could spur lawsuits, boost malpractice insurance rates and ultimately increase medical costs.

These are the opinions of Dr. Douglas R. Bess, a psychiatrist at Emory University School of Medicine. In an article written for JAMA, he cited a study that indicates 65% of drugs purchased in states that have passed drug substitution legislation cost no less than the brand-name drug prescribed; in some cases, generic drugs cost even more.

Another report cited found bio-availability differences between two brands of otherwise identical drugs. "These variations have been recognized as responsible for a few therapeutic failures," Dr. Bess says. "It is probable that other therapeutic failures (or toxicity) of similar origin have escaped recognition."

Editorial Board Expanded

The ISMA Board of Trustees recently enlarged the Editorial Board of THE JOURNAL by adding three positions to be filled by students of Indiana University School of Medicine. Upon nomination by Dean Steven Beering, the Board elected Kathleen Kilcline and Ann T. Moriarty of the Junior class and William Vaughn of the Sophomore class to the newly created slots. The Board also authorized formation of a committee to study the suggestion of further enlargement of the Editorial Board by adding a representative of the residents in training in Indiana hospitals.

Blood Banking Conference

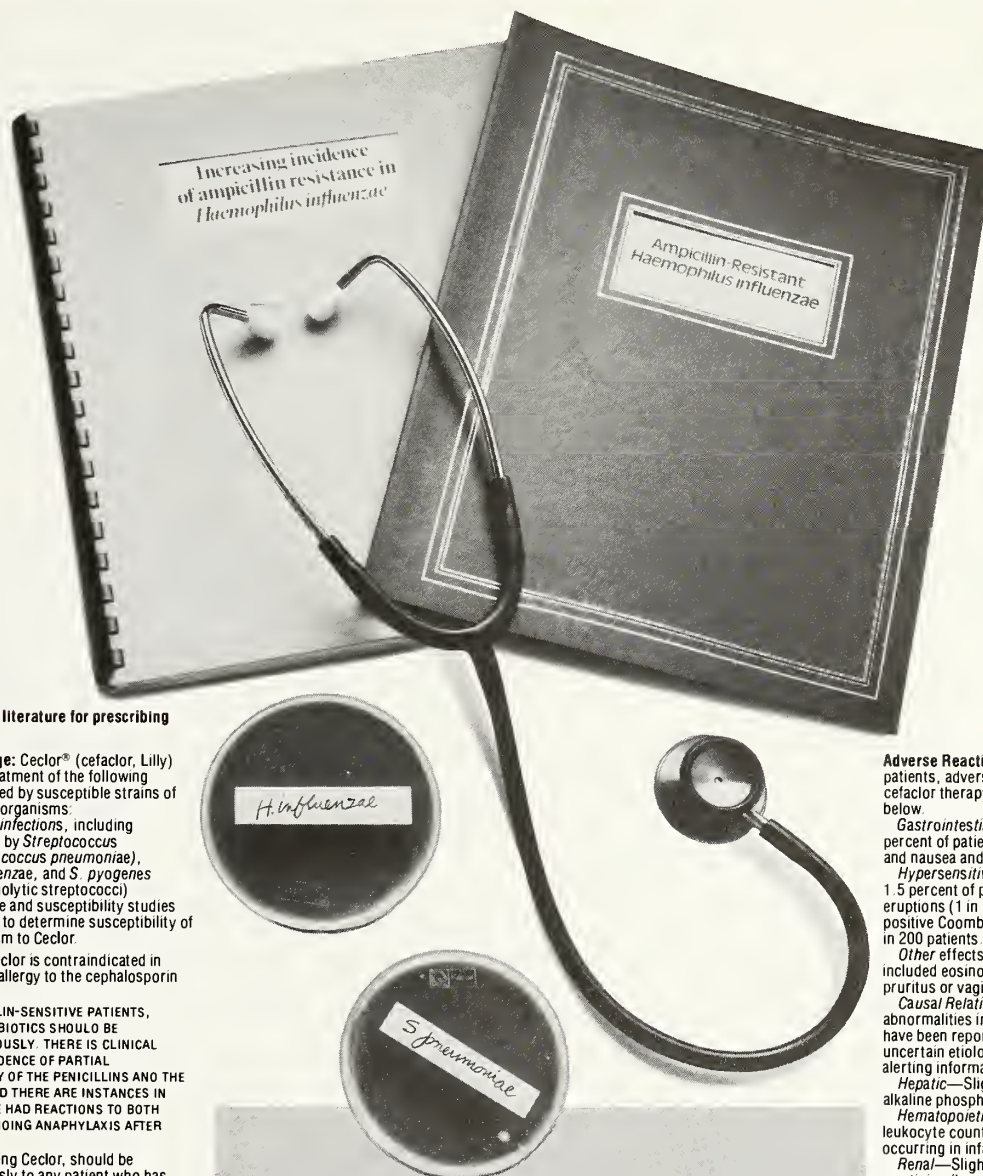
The 1980 Conference on the Management and Logistics of Blood Banking will be conducted June 2-3 at the Regency Hotel, Denver, Colo. It is co-sponsored by the National Heart, Lung and Blood Institute and the American Blood Commission.

The conference will combine theoretical and practical perspectives on the subject of blood resource management. The program will include an examination of fundamental principles, policies and procedures for managing blood resources; objectives and criteria for inventory levels, performance and accountability; alternative models of regional blood service systems; and the implications of current scientific research for resource management in the future.

The registration fee is \$75.

For details, contact Mrs. Nancy R. Holland, Program Coordinator, American Blood Commission, 1901 N. Ft. Myer Drive, Suite 300, Arlington, Va. 22209. Tel: (703) 522-8414.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

Cefclor®

cefclor

Pulvules®, 250 and 500 mg

Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379R]

* Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor® (cefclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

1. Antimicrob. Agents Chemother., 8:91, 1975.
2. Antimicrob. Agents Chemother., 11:470, 1977.
3. Antimicrob. Agents Chemother., 13:584, 1978.
4. Antimicrob. Agents Chemother., 12:490, 1977.
5. Current Chemotherapy (edited by W. Siegenthaler and R. Luthy), II:880. Washington, D.C.: American Society for Microbiology, 1978.
6. Antimicrob. Agents Chemother., 13:861, 1978.
7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases (edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett), p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc. Carolina, Puerto Rico 00630

000482

M.D. Registration Fee Due Soon

The biennial registration fee for all licensed Indiana physicians is due in the office of the Medical Licensing Board of Indiana July 1, 1980. The fee for two years registration is \$40, payable by check or money order.

The Board will mail renewal notices to physicians in June. Physicians should notify the Board in advance of any address change. It is the physician's responsibility to pay the fee whether or not notice is received.

Scheduled AMA Meetings

The AMA House of Delegates will conduct its annual meeting July 20-24 at the Downtown Chicago Marriott Hotel.

The annual Interim AMA House of Delegates meeting is scheduled for Dec. 7-10 at the San Francisco Hilton Hotel, and next year's AMA National Leadership Conference will be conducted Feb. 12-15 at the Downtown Chicago Marriott.

Doctors Should Help Smokers Kick the Habit

Seventy per cent of smokers claim they would quit smoking cigarettes if their physicians urged them to do so, according to Doris Indyke and Bernard H. Ellis, Jr., authors of "There's a Leading Role for Physicians in Helping Smokers to Quit," an article appearing in the March 1980 issue of the AMERICAN LUNG ASSOCIATION BULLETIN.

"The majority of Americans view physicians as health exemplars and feel that doctors should set a good example by not smoking," the authors report.

Apparently, most physicians agree. One study conducted over a 20-year period showed that 60% of physicians were smokers in 1949, compared with 32% in

1967. A more recent study showed that only 21% of physicians were smokers five years ago. And, 82% of doctors surveyed in 1975 believed they should be more active in speaking out on the issue of cigarette smoking.

Service for the Blind

"Recording for the Blind" is a non-profit group which supplies, free of charge, recorded educational materials to blind and otherwise print-handicapped students and professionals. Physicians who know of students who are blind, dyslexic or physically unable to handle books are urged to refer them to Student Services, RFB, Inc., 215 E. 58th St., New York City, N.Y. 10022. Tel: (212) 751-0860.

Abbott to Produce Interferon

The possible antiviral and anticancer actions of interferon heightens interest in the substance and increases the importance of artificial manufacture. Investigative work has been hampered by the cost of purifying interferon from natural sources. Abbott Laboratories is working on a tissue culture method and is also interested in recombinant DNA as a new source.

'Sorvall' Centrifuge Contest

The DuPont Company is celebrating the 30th anniversary of the "Sorvall" line of superspeed refrigerated centrifuges by honoring the owners of the 30 oldest instruments. More than 200 entries were received. The winner is Dr. Albert W. Frenkel, University of Minnesota, whose centrifuge has been in daily use for 26 years. One of the 25 oldest centrifuges belongs to Drs. Joseph S. Ingraham and M. E. Hodes of the I.U. School of Medicine.

Physician Recognition Awards

The following ISMA physicians are recent recipients of the AMA's Physician Recognition Award. This award is official documentation of Continuing Medical Education hours earned, and is acceptable proof in most states requiring CME in re-registration that the mandatory hours of CME have been accomplished.

Addis, Howard M., South Bend
Ahearn, Daniel J., Indianapolis
Allen, Robert K., Indianapolis
Anshutz, William M., Indianapolis
Aronoff, Michael S., Bloomington
Aust, Charles H., Fort Wayne
Bloom, George R., Elkhart
Caddac, Manuel A., Terre Haute
Chan, Macario O., Merrillville
DeLaCotera, Federico G., Munster
Dillon, Gary P., Fort Wayne
Feferman, Martin E., South Bend
Gabriel, Magdi, Mishawaka
Gillespie, Douglas B., Terre Haute

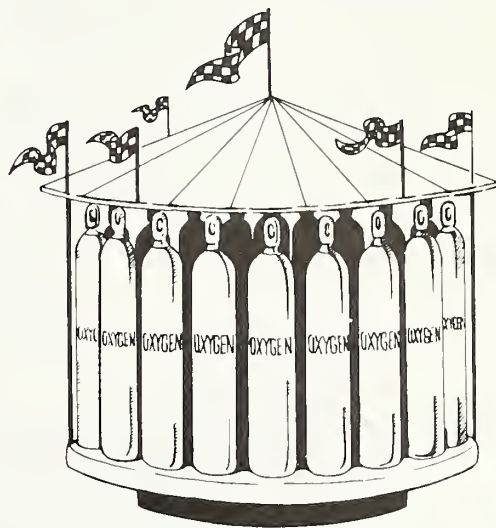
Gustaitis, John W., Munster
Hippensteel, Harland V., Auburn
Huber, Richard G., Bedford
Jensen, Robert E., Fort Wayne
Johnson, John C., Evansville
Kiricenkoff, George J., Mount Vernon
Klutinoty, George, Carmel
Krueger, John E., Fort Wayne
Lee, John W., Fort Wayne
McDonald, Eugene W., South Bend
Mendelson, Stanley M., Kokomo
Merkle, George W., Bluffton
Need, David J., Indianapolis

Nicely, Paulette G., Indianapolis
Parker, Camille K., Logansport
Pope, Howard A., New Albany
Reed, John J., Hobart
Regenstreif, Irving J., Indianapolis
Reidy, James E., Granger
Rendel, Harold E., Peru
Runkle, Max A., Indianapolis
Schulthesis, Richard L., Indianapolis
Suzuki, Tsutomu T., Covington
Tan, Manuel L., Fort Wayne
Towannasut, Verapon, Merrillville
Walter, Robert F., Evansville



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Phone 1-219-432-3321

NEWS NOTES

ISMA Reaffirms Its Stand Against LCCME

The ISMA Board of Trustees voted March 2 to reaffirm its earlier action to recognize only the AMA as the governing body on continuing medical education. The action prohibits ISMA from providing any information or records to the Liaison Committee on Continuing Medical Education (LCCME).

The Board was assured that its action—to recognize only the AMA-CME Committee—would have no impact on individual Indiana physicians in getting credit and meeting CME requirements.

FDA's Toll-Free Number

The Food and Drug Administration has a toll-free number for physicians to call to report problems with drugs, medical devices and in vitro diagnostic products. The purpose is to help the FDA determine when a product poses a significant potential health hazard.

Problems with which the FDA is concerned are hazardous or potentially hazardous products, mislabeling, incomplete or confusing instructions, erroneous information, non-sterile products, packaging errors, and other quality control errors.

The number to call is 1-800-638-6725.



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VA Vocational Rehabilitation

The VA is seeking federal legislation that will allow expansion of the VA vocational rehabilitation program. The agency would like to provide direct job placement services as well as to utilize such services from other governmental agencies and non-profit organizations. The VA also would like to remove the eligibility time limits for all service-disabled veterans who are otherwise qualified for and in need of vocational rehabilitation because of such disabilities.

Here and There . . .

. . . **Dr. William E. Dye** has been elected president of the medical staff at Gibson General Hospital, Princeton. **Dr. Bruce C. Brink Sr.** was elected vice-president, and **Dr. D. E. Pruitt** was elected secretary-treasurer.

. . . **Dr. Frank B. Throop** has been elected president of Winona Memorial Hospital's medical staff. Others elected were **Dr. Evart M. Beck**, president-elect, and **Dr. Richard A. Silver**, secretary-treasurer.

. . . **Dr. James M. Kirtley** of Crawfordsville has been appointed a Sagamore of the Wabash by Governor Otis R. Bowen. Dr. Kirtley is serving his fourth appointment as chairman of the Indiana Commission for the Handicapped.

. . . **Dr. Lowell H. Steen** of Hammond has been named recipient of this year's "Distinguished Internist" award, presented by the American Society of Internal Medicine. The award will be presented May 15 during the ASIM's annual meeting in Washington, D.C.

. . . **Dr. Joseph M. Black** of Seymour has been reelected chairman of Blue Shield of Indiana, Inc.


. . . Among those appointed by the Governor to the newly created 18-man Indiana Council on Physical Fitness and Sports Medicine are State Health Commissioner **Dr. Ronald G. Blankenbaker**, **Dr. Paulette G. Nicely** and **Dr. Thomas A. Brady**, all of Indianapolis.

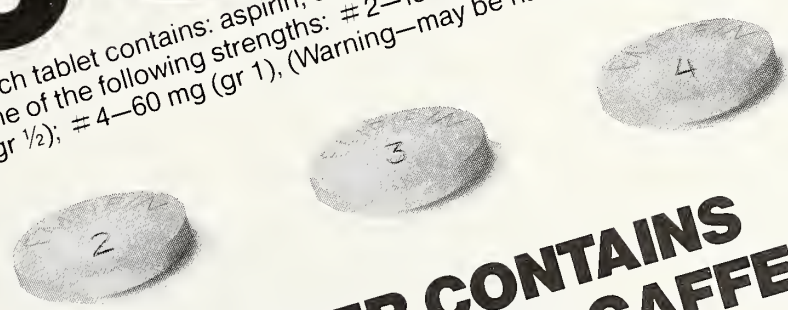
. . . **Dr. Phillip T. Hodgin** of Orleans has been reappointed public health officer for Orange County.

. . . **Dr. Robert W. Briggs** of Indianapolis has been named recipient of the Marion County Medical Society's Physician Community Service Award.

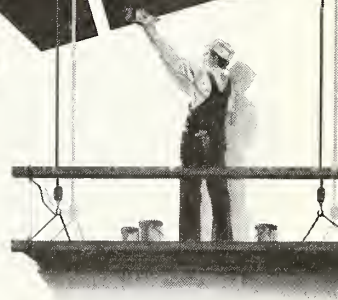
. . . **Drs. James C. Field** of South Bend and **Aly A. Razek** of Evansville were recently made members of the American College of Radiology.

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OBITUARIES

Ruben R. Gaboya, M.D.

Dr. Gaboya, 46, a Bunker Hill internist, died March 7 at St. Joseph Memorial Hospital in Kokomo, where he was chief of staff.

A native of the Philippines, he received his M.D. degree in 1958 from the University of Santo Tomas in Manila.

Dr. Gaboya served as Howard County coroner from 1972 until 1974.

Leon Gray, M.D.

Dr. Gray, 81, a past president of ISMA's Seventh District Medical Society, died March 8 in Morgan County Memorial Hospital, Martinsville.

He received his M.D. degree in 1923 from the University of Louisville. He served in both world wars.

Dr. Gray, Morgan County health officer until he retired last year, was a senior member of the ISMA and was enrolled in its 50-Year Club in 1973. He was a member of the International College of Surgeons, the International Academy of Proctology, and the American Geriatrics Society.



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Lee Brayton, M.D.

Dr. Brayton, 64, an Indianapolis physician, died March 12 at Methodist Hospital, where he was a staff member.

He was a 1941 graduate of Indiana University School of Medicine.

Francis D. Kenney, M.D.

Dr. Kenney, 68, a Munster surgeon, died March 13 at Community Hospital, Munster.

He was a 1941 graduate of Rush Medical School.

Dr. Kenney was a former director of surgery at St. Margaret Hospital, Hammond, and was one of the founders of the Jones Clinic in Munster. He also was one of the founders of the Hammond Surgical Society. Dr. Kenney was a member of the International College of Surgeons and the American College of Surgeons. He was certified by the American Board of Surgery.

Mark H. Mothersill, M.D.

Dr. Mothersill, 93, a retired Indianapolis allergist, died March 30 in a Noblesville nursing home.

He was a 1927 graduate of the University of Michigan Medical School.

Dr. Mothersill, a senior member of the ISMA, worked at the Eli Lilly and Company about 20 years and retired from private practice four years ago. He authored several books dealing with population control. He was a member of the American Academy of Allergy and the American College of Allergists.

Jack E. Pilcher, M.D.

Dr. Pilcher, 75, an Indianapolis surgeon since 1933, died March 23 at his home.

He was a 1929 graduate of Indiana University School of Medicine. He was chief of surgery in the European Theater during World War II.

Since 1970, Dr. Pilcher had served as consultant for the Veterans Administration adjudication department. He was a former governor of the American College of Surgeons and was a past president of the medical staff at St. Vincent Hospital in Indianapolis.

Donald J. White, M.D.

Dr. White, 75, an Indianapolis allergist 50 years, died March 18 at his home.

He was a 1929 graduate of Indiana University School of Medicine and had been a senior member of the ISMA since 1976.

Dr. White was a member of the American College of Allergists and the American Association for Clinical Immunology and Allergy.

COMMERCIAL ANNOUNCEMENTS

MADISON, INDIANA—Luxury office space, finished to your specifications, is now available for lease to physicians in the 606 Professional Building. If you have ever considered relocating to this beautiful, progressive community, please phone for more information. George McAtee, McAtee Management Company, 428 Jefferson St., Madison, Ind. 47250. Phone collect, (812) 265-6800.

VACATION HOMES FOR SALE—Two and three bedroom condominium vacation homes at The Pointe on Lake Monroe, a luxurious golfing community south of Bloomington. Excellent long or short term rental potential. May be purchased furnished or unfurnished. Low 40s to 70s. Call Belva Wilson at Owens, Bryan and Reed, Realtors, (812) 336-6888 or (812) 334-3194.

NEEDED: Staff physician, general practice. Must be medical school graduate and eligible for Indiana license. \$45,000 annual guarantee plus private office (furnished), 40 hours minimum (to vary) per week. Contact Andrew J. Barrett, II, Executive Director, Adams County Memorial Hospital, 805 High St., Decatur, Ind. 46733. Tel: (219) 724-2145.

PROFESSIONAL OFFICE space available in ideal west side Indianapolis Chapel Hill Professional Complex. 1240-3000 square feet. For information, call Mark Genung, (317) 271-1000.

FANTASTIC OPPORTUNITY! If you are a residency-trained family physician and wish to put your 3 years of work to good use, then we invite you to join our busy group. We are 4 board-certified family physicians associated in a practice located across the street from a 90-bed J.C.A.H. full service hospital. This growing rural community offers the potential for a new physician to quickly fill his practice. Its diversified economic base, excellent school system and proximity to major centers (situated between Indianapolis and Chicago) make it an excellent place to raise a family. If you are interested in practicing medicine in a true family practice setting, then the financial aspects of your settling can be mutually negotiated. Contact: Robert C. Kaye, M.D., Professional Corporation, The Clinic of Family Medicine, 1103 E. Grace St., Rensselaer, Ind. 47978.

NEW ALBANY, INDIANA — Physician contemplating retirement. Wants to sell building and equipment. Excellent corner lot opposite Floyd County Memorial Hospital and Professional Arts Building. Call 812-945-5351.

FAMILY PRACTITIONER-TAMPA BAY AREA-FLORIDA—Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., Attn: Jerry Williamson, M.D., 1417 S. Belcher Road, Clearwater, Florida 33516. Tel: (813) 535-3474.

ART INVESTMENTS—Miro, Chagall, Vasarely: 20 to 40% below market prices. Experienced Art Consultant. Contact T. McNulty MFA, 1114 N. Indiana Ave., Bloomington, Ind. 47401.

MADISON, INDIANA—Large, established practice available in near future in beautiful, thriving southern Indiana community. I am retiring, having been in the same location for 40 years. Large office space available. Office equipment and furnishings valued at \$20,000. Will sacrifice at reasonable fee. Wm. A. Shuck, M.D., 414 N. Mulberry St., Madison, Ind. 47250. Tel: (812) 265-3854.

FULLY EQUIPPED medical building for sale or rent. Located in Bunker Hill, Ind., near Kokomo. Address all inquiries to Ruben R. Gaboya, Estate, Box 577, Bunker Hill, Ind. 46914.

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WANTED: Physician for Student Health Center. Excellent facility including laboratory, x-ray and pharmacy. Position available July 1, 1980. Must be licensed to practice in the State of Indiana. Applications received after June 1, 1980 may not be considered. Contact John A. Hetherington, M.D., Director Student Health Center, Indiana State University, Terre Haute, Ind. 47809. Tel: (812) 234-2646. Indiana State University is an Equal Opportunity/Affirmative Action Employer.

DIRECTOR OF EMERGENCY SERVICES—Opportunity available July 1 for a qualified physician to assume the directorship of a modern emergency department. This midwestern university community provides cultural and recreational activities for every member of the family. Earn an excellent income while enjoying the freedom from "on-call" responsibilities. Malpractice insurance provided. For further information, submit credentials in confidence to Mr. Frank Siano, 970 Executive Parkway, St. Louis, Mo. 63141, or call toll-free 1-800-325-3982.

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FOR SALE: Doctor's office building, 30x50, and equipment including x-ray in Dunkirk, Ind. Illness forced doctor's retirement. Hagen West Side Realty. Tel: (317) 768-6471 or (317) 284-6313.

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WHAT'S NEW?

CONTINUED FROM PAGE 268

JEFFERSON INDUSTRIES announces the Econo-Float Wheelchair Flotation Cushion designed for use in wheelchairs or geriatric chairs. May also be used in bed to relieve localized pressure. A special foam pad allows air circulation to reduce possibility of skin maceration. The cushion is filled with water, and five internal baffles reduce water motion. It provides comfortable seating and is effective in prevention of decubitus ulcers.

ACCU-BACK, INC. has a new orthopedic chair and seat pad which may be moved from chair to auto seat or airplane seat. It has two oval-shaped lumbar pads made of temper foam which adapts its form to the individual and adds support to the lumbar curve. The seat and back portion contain high-density foam and conform to the individual. Accu-Back comes in four colors and has its own carrying case.

NORWICH-EATON Pharmaceuticals has announced an accelerated FDA approval of Dantrium® IV, a potentially life-saving drug. Dantrium Intravenous (dantrolene sodium) is an emergency treatment for malignant hyperthermia. The 27 patients treated promptly with Dantrium IV during 2½ years of clinical trials all recovered. Previously the fatality rate was as high as 60%.

RADIAGRAPHITE PRODUCTS has a unique x-ray/film cassette that reduces radiation exposure by as much as 50%. Space age technology produces a graphite component that is strong enough for cassette making. Since graphite is practically transparent to x-rays, a smaller exposure is sufficient. This not only reduces the dosage to the patient but prolongs the life of the tube.

CHEC MEDICAL PRODUCTS is introducing a Bath-Lift for moving disabled patients into and out of the bath. It consists of a chair that rests in the tub with a seat that may be raised or lowered by hydraulic power furnished by the faucet. When the seat is raised, it may be rotated to one side for loading or unloading the patient. When rotated back into line with the tub, it may lower the patient gently into the bath water. The power is hydraulic only; there are no electrical connections.

ORTHO PHARMACEUTICAL announces ORTHO-NOVUM 1/35™ Tablets, a new oral contraceptive with less than 50 mcg of estrogen. The new form provides efficacy rates equivalent to higher estrogen-dose oral contraceptives. A low incidence of amenorrhea and breakthrough bleeding is reported. The progestin level is the same as is provided in ORTHO-NOVUM 1/50 Tablets and ORTHO-NOVUM 1/80 Tablets.

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June 1980 • Vol. 73 • No. 6

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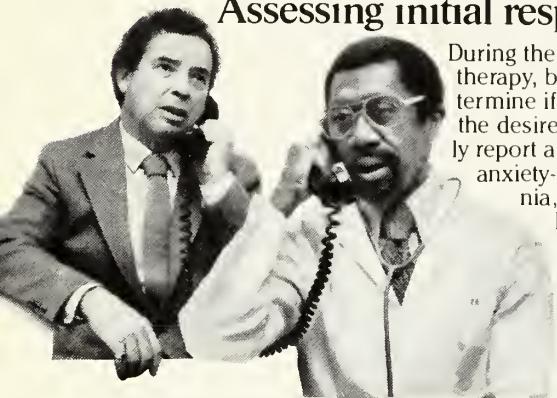
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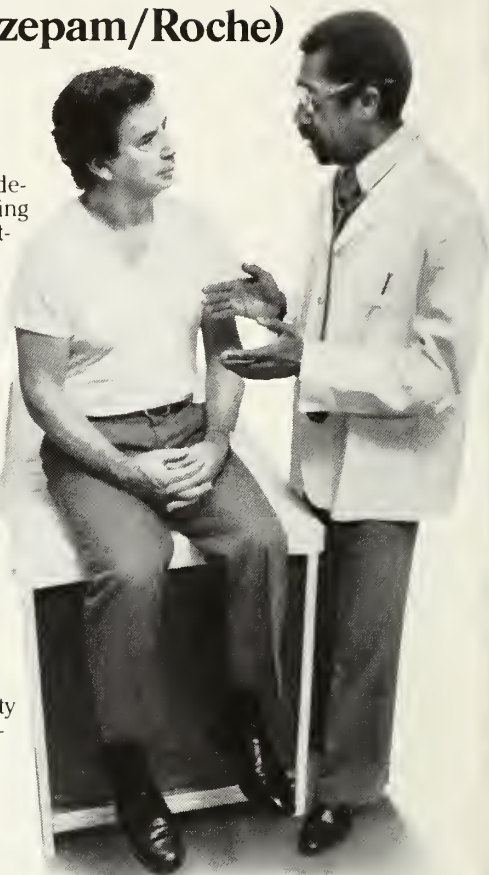
Inside: WELLNESS—THE MOST EFFECTIVE HEALTH INSURANCE
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Monitoring patient response to Valium® (diazepam/Roche)

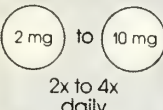

Assessing initial response to therapy



During the first follow-up visit after initiating therapy, both physician and patient should determine if Valium (diazepam/Roche) is having the desired effect. Most patients will promptly report a feeling of relaxation and relief of anxiety-linked symptoms such as insomnia, headaches, palpitations and hyperventilation. You will probably observe that the patient is calmer and more relaxed. If, however, patient response does not measure up to expectations, a reevaluation of the patient's profile with modification of the dosage regimen should be considered.



Making dosage adjustments

START	ADJUST
	

With any psychoactive medication it is good medical practice to initiate therapy at base dosage levels and titrate to the patient's needs. With Valium, experience has shown that 5 mg t.i.d. is usually sufficient although some patients with severe or persistent anxiety may require higher dosages initially. In geriatric or debilitated patients, the recommended dosage is 2 to 2½ mg once or twice daily.

When anxiety fluctuates, as is common with most patients, the dosage may be adjusted as needed during the course of therapy; three strengths in scored tablets give you unmatched flexibility and simplicity in individualizing dosage.

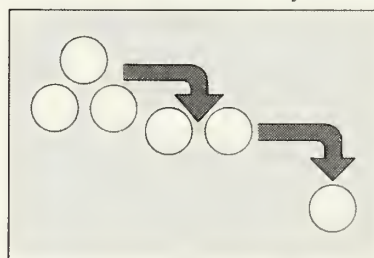
Evaluating progress toward therapeutic goals

SET GOALS					
	1	2	3	4	5
6	7	8	9	10	11
12	13	14	15	16	17
18	19	20	21	22	23
24	25	26	27	28	29
30	31				

At the beginning of therapy it is now common practice for both physician and patient to establish treatment goals and to estimate the amount of time needed to achieve them. Then the patient knows what to expect and when to expect it.

Some physicians find that compiling a checklist of presenting symptoms and complaints is useful for assessing the patient's response from visit to visit. In this way, progress toward attainment of the therapeutic goal is reviewed at regular intervals. As patients feel their symptoms abate and begin to develop insight into the sources of their anxiety and psychic tension, the checklist can be expected to dwindle.

Discontinuing pharmacologic intervention



When you decide to discontinue therapy, tapering dosage is good medical practice. Although rarely necessary after short-term treatment with Valium, gradual dosage reduction is advisable for patients who have been on extended therapy. This gradual discontinuance should preclude either recurrence of pretreatment symptoms or development of untoward side effects. Symptoms of withdrawal have almost always been associated with abrupt discontinuance of therapy at higher dosages taken continuously over long periods of time.

2-mg, 5-mg, 10-mg scored tablets
Valium®
diazepam/Roche

An Important Adjunct to Your Treatment Program for Excessive Anxiety



See the following page for a summary of product information.

Valium® (diazepam/Roche) ®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Tension and anxiety associated with anxiety disorders, transient situational disturbances and functional or organic disorders, psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders, atetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium (diazepam/Roche) in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma, may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed, drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported, should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Tension, anxiety and psychoneurotic states, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

Supplied: Valium® Tablets, 2 mg, 5 mg and 10 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50, available in trays of 10.



Roche Laboratories
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WHAT'S NEW?

DETECTO SCALES COMPANY announces a new chair scale that weighs patients while they are seated. The correct weight lights up on a digital display panel. A convenient fold-away foot rest supports the feet during weighing. Available in either 110- or 220-volt power and also may be had with a battery pack.

THE 3M COMPANY makes note paper that is partially coated on the backside with an adhesive that will adhere the note or tape to almost any clean dry surface. It will remain in place as long as needed and then can be easily removed without leaving a stain on the host surface. 3M calls this "Post-it" Notes and Tape. The invention will do away with most of the need for thumb tacks, paper clips, staples or separate sticky tape. Post-it Note products come in pad and tape form in several sizes.

RIKER LABORATORIES have just released a new gentle liquid skin cleanser. It is a low pH product and bears the name "pHresh 3.5 Finnish Cleansing Liquid." It is non-alkaline, non-irritating and non-drying. It was developed and marketed originally in Finland. It is soapless and helps maintain the skin's normal acidity and protects against irritations caused by drying alkaline soaps and detergents.

REVERE CORPORATION is offering a mobile stainless steel and fiberglass bath table that may be used in the operating room or in the patient's room for complete cleansing of burns. It may be used as a transport stretcher. It is fitted with inlet and outlet hoses and may be used for bathing and dressing patients in shock or with skin grafts.

THE 3M COMPANY makes a disposable polyethylene pouch to be attached to surgical drapes and used during operations for storage of cautery tips, suction devices and other instruments. Two adhesive strips hold it in place. The exterior wall of the pouch is transparent to allow visibility of contents.

THE ORTHOPEDIC EQUIPMENT COMPANY of Bourbon, Indiana has added an orthopedic extension device that provides easier, accurate positioning of patients for orthopedic procedures when used in conjunction with general surgical tables. It is especially valuable for procedures requiring use of mobile C-arm image intensifiers and provides greater clearance for positioning and movement of the C-arm both before and during operation.

CONTINUED ON PAGE 420

News of what is new in the medical supply industry is composed of abstracts from news releases by manufacturers—of pharmaceuticals, clinical laboratory supplies, instruments and surgical appliances—and book publishers. Each item is published as news and does not necessarily constitute an endorsement of a product or recommendation for its use by THE JOURNAL or by the Indiana State Medical Association.

The JOURNAL

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Indianapolis, Ind. 46208
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All issues since 1967 available on microfilm from University Microfilms, Inc., 300 N. Zeeb Rd., Ann Arbor, Mich. 48106. Indexed in Index Medicus and Hospital Literature Index.

Advertising rates and data available on request. Representative for national advertising: State Medical Journal Advertising Bureau, Inc., 711 South Blvd., Oak Park, Ill. 60302.

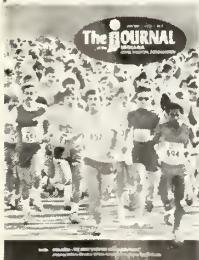
Publication deadline: 1st day of month preceding month of issue.

Subscriptions: \$14 per year, USA; \$16, Canada; \$17, foreign; \$12, libraries; \$10, senior ISMA members; \$8, members, except for special issues, single copies not available. Subscriptions renewable only in January and July.

Second-class postage paid at Indianapolis, Ind. and additional mailing office.

ABOUT THE COVER

Senator Richard G. Lugar of Indiana joins other running enthusiasts during last year's six-mile race at Butler University. The "Dick Lugar 1980 Running Series"—the Series is the first such program in the United States—began in March and ends with a grand finale in October. See Page 344.



MEDICAL MUSEUM NOTES



CHARLES A. BONSETT, M.D., Indianapolis

THIS PAGE OF NOTES consists of additions and corrections to the Notes pages of the three preceding issues of THE JOURNAL.

First, the March issue, which featured a street car and a horse and buggy on the front cover. Several readers called attention to the fact that the street car had no trolley and that three rails were present instead of the usual two.

The question was raised as to the motive force of the car; was it really a street car or was it a cable car? Another reader answered the question, stating that at this particular period in time two cities in the United States used the three-rail system for their trolleys: Washington, D.C. and Manhattan in New York City.

Another reader noted in the left foreground of the picture the very short radius curve of an older pair of tracks, suggesting that these had been used by a horse- or mule-drawn car.

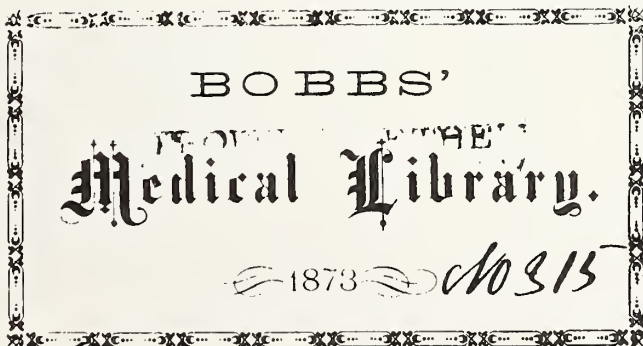
We never discovered the original medical purpose of the illustration, but we did learn that many readers of THE JOURNAL are rail buffs.

Next, the April issue of THE JOURNAL and Dr. John Bobbs. Two errors here need correction just to keep the record straight.

St. Clair, not St. Claire, is the correct spelling of the street where the library housing the bronze bas-relief of Dr. John Bobbs is located. We used both spellings. Unfortunately, only one is correct.

The second error concerned the date of the memorial. It should have been 1916, not 1914.

Mention was made that only one book from the original Bobbs library survived the devastating fire that destroyed the medical school in 1894. This book, which was about prostitution, had been borrowed by a physician at the Central Indiana Hospital for the Insane. It was found several years ago in the library of the Old Pathology Building, now the Museum. The original bookplate is reproduced below.



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Finally, the May issue, which told about Dr. Mary Thomas, ISMA's first woman member. These additional comments do not concern Mary but rather her husband, Dr. Owen Thomas.

Dr. Owen Thomas was never a member of the Indiana State Medical Society. Reproduced above is an advertisement from the 1857 Richmond, Ind., city directory. The bold type of Mary's name, in contrast to Owen's, suggests that she was the principal partner.

Subsequent issues of the city directory indicate that Owen became a pharmacist and later a dentist. On Mary's death in 1888, he moved to Michigan to live with a daughter.

WELLNESS:

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"I encourage all Hoosiers to look seriously at taking the personal initiatives of eating right, exercising regularly and maintaining a conscientious lifestyle."—Sen. Richard G. Lugar (R.-Ind.)



Senator Lugar

MORE AMERICANS than ever before are participating in sports and physical exercise. Jogging and competitive running are leading the exercise boom. Of those who exercise regularly, 24% are joggers. In fact, a recent Gallup Poll indicates that eight of every 100 adults run at least a mile a day, while many run much farther. Entries for the Boston Marathon this year will set an all time record for the event. While most Americans will never run in the marathon, many might consider running around the block.

The jogging phenomenon sweeping the country carries important implications for government policy-makers, and this is where I believe public officials can make an important contribution to physical fitness—through personal example. I run about 18 miles a week in the area near my home, as I have for several years, or around the grounds of the Capitol after the Senate has concluded its business for the day. While Mayor of Indianapolis, I initiated the annual Mayor's Mile Run at Arsenal Technical High School. Many persons who participated with me in the event, or knew someone who joined in, or just watched a news clip on television, discovered that running a mile is not a superhuman feat. Ever since, I have enjoyed participating in running events all over Indiana.

The increasing number of Americans participating in physical exercise raises broader policy considerations. Without any government interference or coercion, private citizens by the millions are participating in a movement that will

improve individual health and productivity.

It is clear from the mail I receive that, with the exception of military preparedness and inflation, no other set of issues is more important to Hoosiers than health. Ironically, while the Administration is proposing new bureaucracies and more complex regulations aimed at holding down hospital costs, individuals making free choices are saving the country millions of dollars annually by reducing demands on our health care facilities.

Proposals before the Congress for various degrees of comprehensive health insurance—and a variety of other health care measures—are not moving along because the predicted costs run into the tens of billions of dollars and because the changes projected for current institutions would be profound and cause serious disruptions in the present delivery of services to the public.

Even a modest national health insurance program would call for the federal government to spend \$34 billion, and if it is determined that a more comprehensive program is desired, a "cradle-to-grave" plan would cost American

taxpayers over \$80 billion annually. At a time when inflation is running in double digits and the federal government is already spending billions of dollars it does not have, such programs are unacceptable.

The single most effective governmental approach to lowering health care costs would be to provide greater encouragement for individuals to exercise and to take other preventive medical precautions. Most Americans believe that first class hospitals, emergency care procedures, and the availability of extraordinarily talented doctors, nurses, and other health care professionals are needed. But also needed is information that will help each American devise a wellness program to prevent illness, prolong life expectancy, and substantially increase the quality of the years we are given to live.

One of my major objectives in the United States Senate has been to encourage sound programs that will make a substantial difference in the health of Americans. I encourage all Hoosiers to look seriously at taking the personal initiatives of eating right, exercising regularly and maintaining a conscientious lifestyle.

The Dick Lugar Running Series 1980 is my most recent effort to increase public awareness of the benefits of individual health care initiatives and to participate in the form of physical exercise I enjoy most—jogging. At each Series event an eminent authority will be on hand to discuss preventive medicine and exercise in general; a 10,000 meter race will provide jogging enthusiasts with the opportunity to compete head to head with other runners in their area and statewide. Running Series races

will be held in Indianapolis (June 21), Evansville (July 27), Jeffersonville (Aug. 9), Lafayette (Sept. 14), South Bend (Sept. 21), and Indiana Dunes (Oct. 5).

As a by-product of this Series, a state champion in the various women's and men's divisions will be crowned at the conclusion of the first Indiana "Race of Champions" to be held at the Indiana Dunes State Park. The winners of each age division in the preceding races will face off at this grand finale of the Running Series.



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LETTERS

Physician Offers Peer Review 'Ground Rules'

Much has been said in our journals about peer review. Yet nowhere have I seen clearcut guidelines published that will assure its skillful application. There has been much bungling and clumsiness in attempting peer review because of our lack of skills in this area. The issue is not so much whether we'll do it, but rather how we should do it.

The government would like to thrust upon medicine this awesome job of peer review. It sounds simple, but it's really very complex and sticky.

Peer review demands a clear process of gathering data in making judgments and evaluations. No matter how carefully this is done, toes get stepped on. To be a "friend" it may be necessary to whitewash glaring deficits in standards. The other extreme is to take up the torch of righteous indignation, point the finger at colleagues, and create a witch hunt. Guidelines for the skillful handling of peer review are necessary if a creative, upgrading experience is to be expected.

Perhaps medicine can learn something from many fine industries that have discovered the ways of self-assessment and solving internal conflict in order to survive the pressures of competition. Likert and Likert have captured *New Ways of Managing Conflict* in their book—born out of the struggles of

industry in its efforts to achieve a high degree of performance excellence. Perhaps the health industry needs more of this self-chosen goal rather than awaiting a governmental edict.

Below are a few ground rules for peer review. They are some of the skills needed to achieve the goals most of us desire.

- There must be an awareness that physician attitudes may have more to do with the quality of medicine than actual techniques, knowledge or all sorts of rules and regulations. Governmental regulations or hospital staff rules will never change physician attitudes. Many malpractice claims begin with a careless attitude on the part of one physician against another; such an attitude may be manifested by a critical statement, which a patient may capture to serve his own wishes.

- A nurturing, non-judgmental, magnanimous attitude can build a just and lasting basis for peer review. Webster defines "magnanimity" as "loftiness of spirit enabling one to bear trouble calmly, to disdain meanness and revenge, and to make sacrifices for worthy ends."

- If peer review cannot be approached in any staff with magnanimity, the objectives for which we strive will not be reached, and it will be a degrading experience. Most certainly, if professional jealousy, personal animosities, or vindictiveness are allowed to color the picture, only division and disharmony of the staff can result. Constructive criticism is helpful and necessary in any institution, but criticism born out of hostility and narrow attitudes will only be destructive.

In other words, successful peer reviews require that, unless disciplinary action is clearly indicated, no physician or case should be singled out for staff discussion; there should be no witch hunts; equal

time should be given to everyone; and physicians must be aware that their decisions can be challenged at any time. Finally, specific goals should be set before any peer review is undertaken.

E. L. HOLLENBERG, M.D.
Treasurer
Medical Licensing Board
of Indiana

Testing for Malignant Hyperphenylalaninemia

We are trying to determine whether all infants and children who have had high neonatal phenylalanine concentrations, yet did not have PKU, have been tested for so-called "malignant hyperphenylalaninemia."

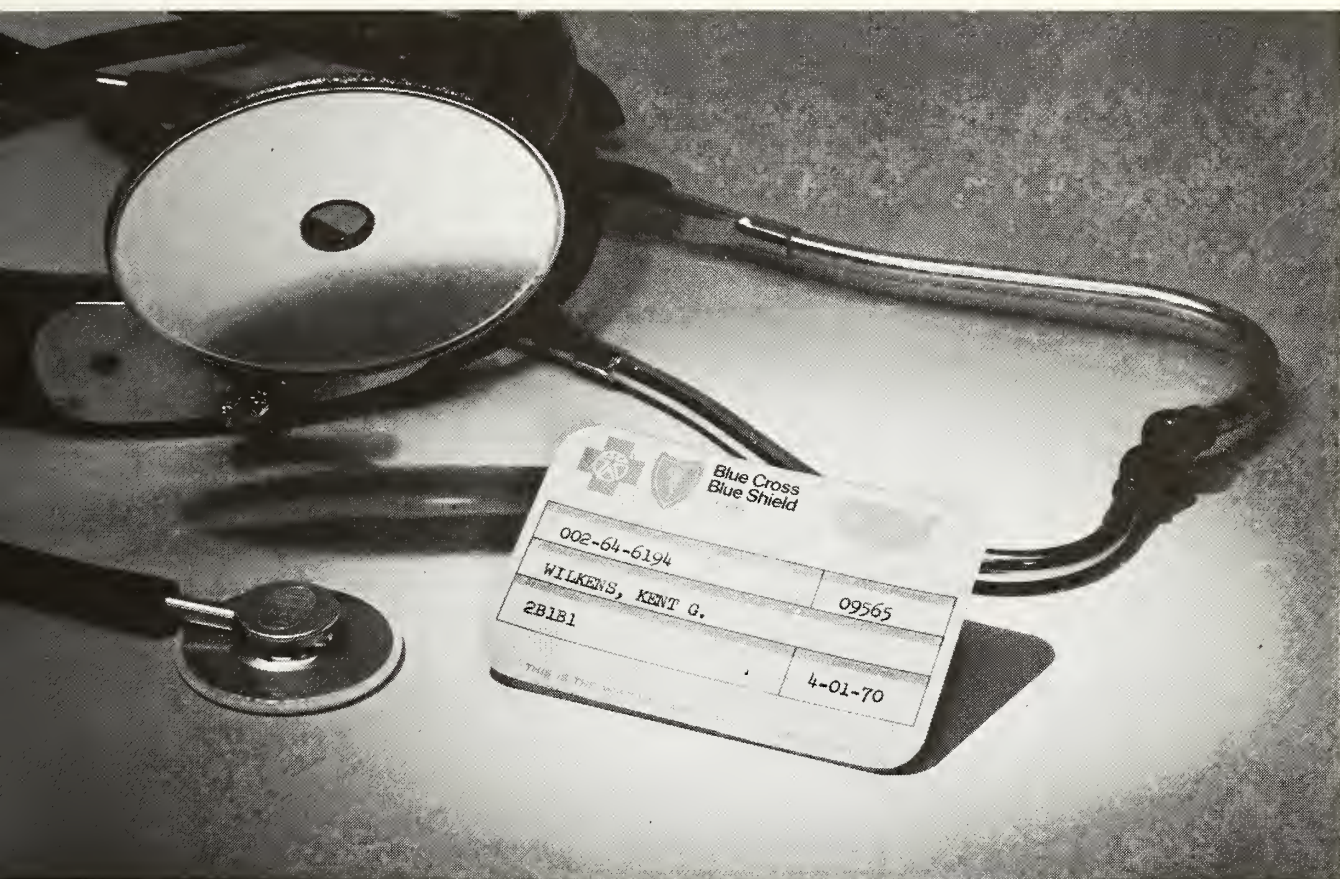
In this disorder, present in almost one per cent of infants diagnosed as having PKU, patients maintained on proper diet control have gone on to have neurological problems, occasionally severe enough to result in death in late infancy, although patients with milder symptoms have been described. In these patients there appears to be a deficiency in the production or regeneration of the cofactor for the enzyme phenylalanine-hydroxylase, bipterin; this is also a cofactor for enzymes catalyzing the hydroxylation of tryptophan and tyrosine, thus synthesizing the precursors of several neurotransmitters. It is the marked reduction in neurotransmitters that is thought to bring about the clinical picture.

This disorder must be distinguished from classical phenylketonuria at the time that therapy is started. This may be done by determining the urine concentrations of vanillylmandelic acid and 5-hydroxyindoleacetic acid relative to the creatinine concentration to make certain that the patient does not have a deficiency in the generation of

CONTINUED ON PAGE 348

Letters will be published as space permits and at the discretion of the editor. They will be subject to editing. Reader response is encouraged. Letters should be addressed c/o THE JOURNAL of the Indiana State Medical Association, 3935 N. Meridian St., Indianapolis 46208.

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LETTERS

Testing for Malignant Hyperphenylalaninemia

CONTINUED FROM PAGE 346

these substances. A more efficient test is that of noting the rapid reduction of the serum-phenylalanine concentration in these patients after administration of biopterin; patients with classical PKU show no response. Unfortunately, biopterin is not available in the United States at the present time; efforts are under way to produce enough of a supply so that this may be employed in routine differential diagnosis. Another efficient diagnostic method not yet generally available is the determination of the excretion pattern of urinary pteridines.

It is of great importance to make this differentiation. There is a treatment available for the so-called "malignant" form; this consists of administering biopterin or a combination of levodopa, 5-hydroxytryptophan, and carbidopa to provide the missing products. This may prevent the symptoms of the disorder and, indeed, ameliorate many of those which have already become established in the case of late diagnosis. Another point of significance is that in some of the patients the disorder is due to deficiency of the enzyme dihydropteridine reductase, which is normally present in white blood cells and cultured amniotic fluid cells; for this reason, diagnosis may be definitively established and amniocentesis diagnosis carried out in subsequent pregnancies; the latter have the usual 25 per cent recurrence risk for autosomal recessive disorders.

It is of particular importance that this situation be called to the attention of all physicians who have had any patients with hyperphenylalaninemia, defined as a serum-phenylalanine concentration above normal but below 15. While the classic cases of phenylketonuria are

under treatment and have had attention paid to this matter, the lack of necessity for diet control when the phenylalanine concentration has been under 15 has resulted in a number of infants who have not been followed up. Yet, these children may have "malignant hyperphenylalaninemia," presumably in a milder form, or even in a major form which has remained unexplained.

It is requested that all Indiana physicians who have provided medical care for infants with higher-than-normal phenylalanine concentrations at birth have these infants studied for the possibility of "malignant hyperphenylalaninemia." Older children who had a diagnosis of hyperphenylalaninemia made in infancy and who have any neurological or psychological impairments similarly should be studied.

Please call the undersigned if you desire additional information. A succinct review may be found in several brief articles in the April 1980 issue of *PEDIATRICS*, beginning on pages 837, 840 and 844.

IRA K. BRANDT, M.D.
REBECCA S. WAPPNER, M.D.
Riley Children's Hospital
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I.U. Med Students Hope to Form Group To Provide Input

In 1973 the AMA created a national medical student organization, the AMA Student Business Session. This group meets at regularly scheduled business meetings to provide student input into the AMA.

Since its inception the AMA-SBS has become quite large and active. At the last AMA meeting in Honolulu, the students introduced over half the resolutions submitted to the AMA floor. Students from Indi-

ana University School of Medicine were among the most active at recent meetings.

A natural outgrowth of this national medical student group has been organization on the state level in association with state medical societies. This has been accomplished in a number of states. The goal of these student organizations on the state level is to provide student input into the state societies, introduce medical students to the activities and functions of state societies and thereby increase membership and activity within the state and national medical associations.

In the future, students will be joining a number of ISMA committees and commissions. It is hoped that an ISMA-SBS (Student Business Section) may eventually be formed. We look forward to working with members of the ISMA.

FRED SNOY
CARL OTTEN

I.U. School of Medicine
Student Business Session

New Guidelines For Cancer Checkups

The American Cancer Society has modified its recommendations to the public about the frequency of checkups for the early detection of cancer. The Society feels its new guidelines "will result in greatly reduced inconvenience, risk and cost to the patient."

An article on this subject appears on pp 362-364. THE JOURNAL is interested in hearing pros and cons concerning this or any other issue that you feel should be brought to the attention of the Indiana State Medical Association. Drop us a line!



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The Foundation is managed by a board of directors that comprises the members of the ISMS Executive Committee. At present, proceeds from the Foundation investments are awarded to THE JOURNAL to further the continuing medical education program.

Memorial contributions made to the Foundation in lieu of flowers will be acknowledged by the secretary in a letter to the family of the deceased.

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Motrin[®] vs codeine...

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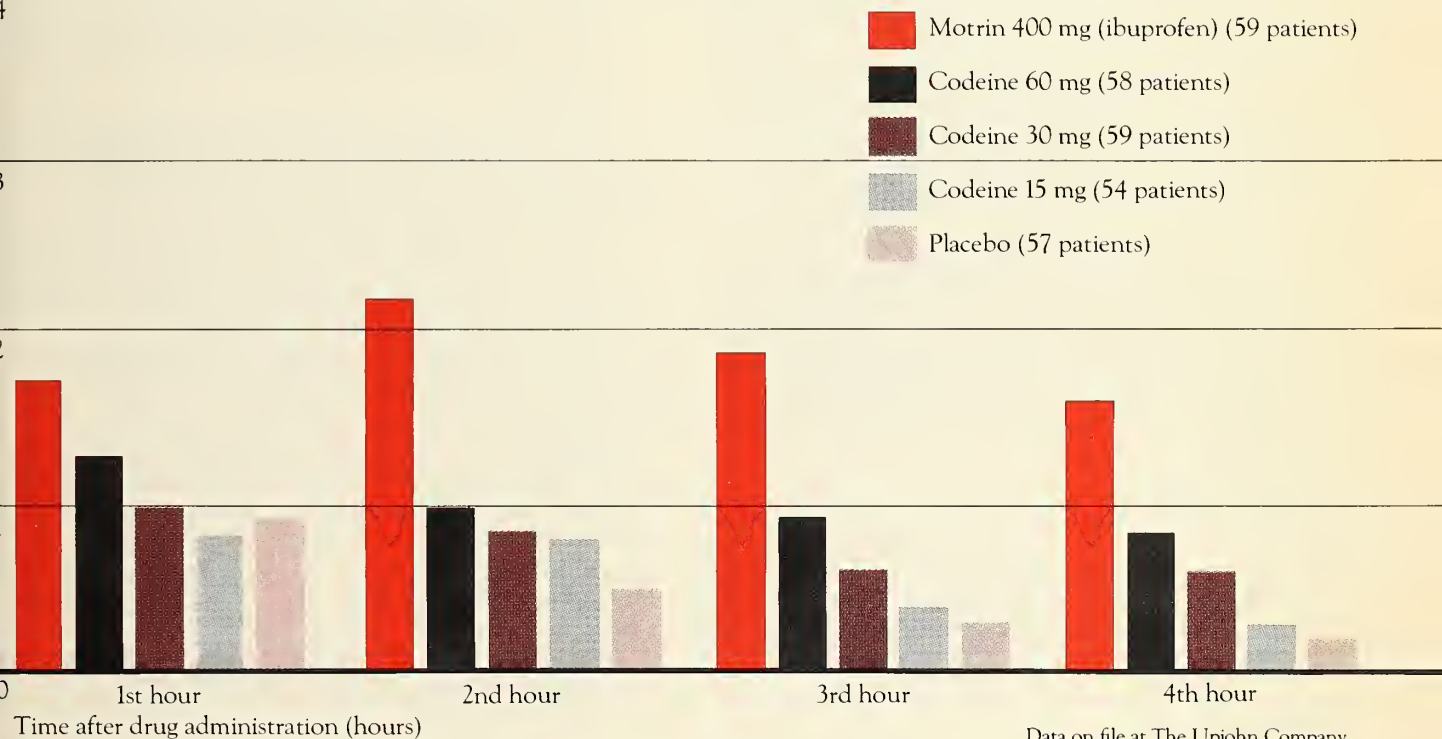
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Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. **Coumarin:** Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

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EDITORIALS

Politics Takes Precedence Over Needs of the Sick

"A governmentally organized and controlled health care system produces neither a healthier population nor more efficient allocation of health resources."

Such is the stated conclusion of a new study evaluating the National Health Service (NHS) in England. The study was made possible by a grant from Roche Laboratories. It was conducted by Cotton M. Lindsay, Ph.D., professor of economics at Emory University. In 1979 he wrote "Canadian National Health Insurance: Lessons for the United States."

His co-author was Arthur Seldon who is co-director of the London Institute of Economic Affairs, and a First Class Honors graduate of the London School of Economics.

Lindsay pinpoints the chief problem: "Government . . . shifts the attention of decision makers away from satisfying patient needs toward achieving some political objectives."

He also reminds us that the theories that created the problems inherent in nationalized health care are still being used today—30 years later—to support national health insurance proposals in the U.S.

The theories are: Health care is more accessible if it's "free" and, to be efficient, the market system must be replaced by government direction.

The author concludes: "Banishment of price from the health care market under NHS has not created additional resources to provide for the needs of those previously unable or unwilling to pay for them. It has simply resulted in a new rationing scheme that is not any less arbitrary or inequitable than the price system it replaced."

Reducing the price results in more demand for services and an alternate form of rationing must substitute for price rationing.

Dr. Lindsay: "Health care—particularly hospital care—though "free" in a monetary sense is rationed in the NHS on the basis of people's willingness to pay the price of suffering delay in its delivery."

Second Opinions: Useful or Worthless?

Second opinions are priceless in cases of doubtful diagnosis or debatable treatment if either the patient or the physician desires outside advice. A conference with a colleague congenial with the patient and physician serves a purpose that is unique in medicine for counsel, reassurance and enlightenment.

Second opinions mandated by law or regulation are at the other end of the scale. Unwelcomed by the patient or physician, the second opinion merely adds to the expense, prolongs the diagnostic procedure, intro-

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MED B-4-S

CONTINUED ON PAGE 358

Nostalgia: The Medicine Show

Commentary

L. A. ARATA, M.D.
Shelbyville

WHEN SUMMERTIME came to Indiana in the pre-depression and early depression years of my growing up, the itinerant medicine shows also came. For those who never saw one, I tell of some.

In our town (Mishawaka) there were two vacant fields in regular use in different parts of town. The show would spend a week at one lot, then move to the other side of town. It was staged on the bed of a truck whose sides were hinged to be let down to increase the size of the stage. The cast consisted of three or four men and the wives of one or two of them. At least one man was an Indian.

After supper, a crowd assembled in the field and the show was on. There was piano, ukelele, and/or guitar or banjo music, dancing by some of the show people, audience participation in the dancing, and the grand finale of a black-faced

comedian comedy skit. Between the entertainment portions, medicine was barked from the stage and sold through the crowd by the show people. I can still hear the cries of "Good for the ills of man or beast. Use it internal, external, eternal!" and the corn cure "good for corns, callisters (callouses?), bunions."

There were a few minor variations in the program from night to night, and from show to show. The medicines were all liquids, and were made from old secret Indian recipes containing "roots, yarbs (herbs?), barks, and berries." I do not remember hearing the words *snake oil*.

For two or three years, an Indian named Red Feather rented the back field owned by my father. He paid Dad a princely rental of \$10 or \$15 a week for the week or two that he used it. That was a very large rental sum. After using Dad's land for two or three seasons, Red Feather lost his life in an automobile accident somewhere in the U.S.A. Too bad!

One of Red Feather's products was his hair-growing remedy. The Indian had long black hair, and to show that it was real and not a wig, he would get some small boy up on the stage, and have the lad grasp the hair tightly with both hands. Red Feather would then turn around rapidly on stage with the lad whirling about with his feet in the air. This little feat sold lots of hair restorer to the men.

Where the shows came from prior to our town, and where they went to after leaving our town will forever remain mysteries to me. Why this piece of Americana has been lost—except to the memories of a few of us—is another mystery.



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Emergency Medicine in Indiana: Past, Present and Future

JOHN C. JOHNSON, M.D.
Evansville

THE AMERICAN COLLEGE of Emergency Physicians (ACEP), organized nearly 12 years ago, gained national recognition last September when the American Board of Medical Specialties created the nation's 23rd recognized medical specialty by giving its approval to the American Board of Emergency Medicine (ABEM).^{1,2} Since February, ABEM has been offering certification in Emergency Medicine to its many followers through a written and practical examination process.

Locally, the Indiana Chapter of the ACEP was chartered in 1972.⁴ Two years later at the behest of Indiana Governor Otis R. Bowen, M.D., the Indiana Governor's Conference on Emergency Medical Services was held in Indianapolis which subsequently led to the passage of Public Law 55 establishing the Emergency Medical Services Commission in 1974. In 1975, action on similar resolutions from Marion and Randolph County Medical Societies created the Section on Emergency Medicine of the Indiana State Medical Association.^{5,6} (See *Tables 1 and 2* for a more detailed review of Emergency Medicine.

The author is president of the Indiana Chapter, American College of Emergency Physicians.

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Acknowledgement: Mr. E. Nicholas Kestner, Executive Director, Indiana Chapter, ACEP, for his assistance with the Emergency Medicine Teaching Survey in Indiana.

TABLE 1. BRIEF HISTORY OF EMERGENCY MEDICINE^{1,2,3,4,5}

Date	Event
1968 Aug. 16	American College of Emergency Physicians (ACEP) incorporated (Lansing, Michigan).
1969 Aug. 16	First ACEP state chapter chartered (Massachusetts).
1970 March 6	University Association for Emergency Medicine (UA/EM) organized (Birmingham, Alabama).
1970 June	Emergency Department Nurses Association (EDNA) organized.
1970	National Registry for Emergency Medical Technicians (NREMT) organized (Columbus, Ohio).
1970	First Emergency Medicine Residency Program started (University of Cincinnati).
1972 January	Indiana Chapter ACEP chartered.
1972 June 10	Emergency Medicine Foundation (EMF) established.
1973 January	AMA Board assigned Commission on Emergency Medical Services.
1973 June	AMA House of Delegates gives provisional status to Section on Emergency Medicine.
1973 July	Federal Emergency Medical Services Systems Act (EMSSA) of 1973 authorizes \$185 million over three years.
1974	Indiana Public Law No. 55 establishes the Indiana Emergency Medical Services Commission.
1974 November	Emergency Medicine Residents Association (EMRA) founded.
1975 March	National Association of Emergency Medical Technicians (NAEMT) founded.
1975	Indiana Public Law No. 142 provides for Advanced Life Support in Emergency Medical Services.
1975 May 23	Society for the Teachers of Emergency Medicine (STEM) organized.
1975 October	Indiana State Medical Association Section on Emergency Medicine approved.
1975 December	AMA House of Delegates gives Section on Emergency Medicine permanent status.
1976 January	EMSSA of 1973 extended through additional \$33.6 million appropriation.
1976 March	American Board of Emergency Medicine (ABEM) application for primary specialty board approved by Liaison Committee for Specialty Boards (LCSB).
1976 June 27	ABEM officially organized.
1976 September	EMSSA of 1976 amends Act of 1973 for three additional years.
1977 June	AMA Council on Medical Education (AMA/CME) approves ABEM application for primary board.
1977 Sept. 15	American Board of Medical Specialties (ABMS) opposes ABEM's primary board application.
1977 November	STEM accepted into Council of Academic Societies of the American Association of Medical Colleges (AAMC).
1979 February	LCSB approves ABEM application for conjoint board.
1979 February	AMA/CME approves ABEM application for conjoint board.
1979 Sept. 21	ABMS approves ABEM application for conjoint board— Emergency Medicine Becomes 23rd Recognized Specialty.
1979 Dec. 12	EMSSA of 1979 amends Acts of 1973 & 1976 for three additional years and \$194 million (PL 96-142).

TABLE 2. INDIANA LEADERS IN EMERGENCY MEDICINE^{4,6}

	INDIANA CHAPTER AMERICAN COLLEGE OF EMERGENCY PHYSICIANS ^a				ISMA EM SECTION ^b
Year	President	President-Elect	Secretary	Treasurer	Chairman & Delegate
1972	Joseph McPike	not applicable	Milton Daus	Lindley Gammel	not applicable
1972	Jacob Vandrunen	Paul VanKirk	Phillip Kellar	Lindley Gammel	not applicable
1973	Paul VanKirk	Joseph McPike	Phillip Kellar	James Brantly	not applicable
1974	Joseph McPike	Harry Tunnell	Forest Kendall	Martin Graber	not applicable
1975	Harry Tunnell	Martin Graber	Forest Kendall	William Nice	Michael Bishop
1976	Martin Graber	William Nice	David Gettle	Stephen Miller	Michael Bishop
1977	William Nice	David Gettle	Esther Schubert	Stephen Miller	David Gettle
1978	David Gettle	Michael Bishop	Esther Schubert	Esther Schubert	John Johnson
1979	Michael Bishop	John Johnson	Esther Schubert	Esther Schubert	John Johnson

a. Chartered January 1972, elections in May every year.

b. Approved October 1975, elections September-October every year.

Emergency services at the Indiana University School of Medicine have been traditionally provided at the William N. Wishard Memorial Hospital (formerly Marion County General and City Hospitals), which is managed by the School of Medicine through a contractual arrangement with Marion County (Indianapolis). The emergency room facilities at Wishard Hospital, perhaps the most up-to-date in the state, care for the second largest number of patients presenting to an Indiana emergency room each year; Methodist Hospital (Indianapolis) sees a slightly larger volume. The emergency department at Wishard is staffed by postgraduate physicians (housestaff) and students, with attending physicians from the school's various clinical departments lending support. There are, however, no fulltime specialists in emergency medicine providing coverage for the facility. The other hospitals on the medical center complex have receiving rooms which are not staffed by physicians.

There are more than 271 full-time emergency physicians managing emergency rooms in Indiana hospitals.⁴ Of the 244 emergency physicians who are members of ACEP, 125 report they are actively involved in teaching medical students, interns and residents.⁴ (See Table 3) An additional, 27 non-

ACEP members who are emergency physicians also report similar teaching activities.⁴ The time these 152 emergency physicians spend teaching emergency medicine is provided gratis, just as many Indiana physicians in other medical specialties provide time teaching in their area of expertise free of charge.

There is a difference between emergency physicians who teach and other Indiana physicians who teach. Nonemergency physicians involved in medical teaching, either at the medical school or in hospitals separate from the medical center, are partially rewarded for their efforts with the conveyance of a faculty title in their particular department from the Indiana University School of Medicine. Emergency physicians who provide similar teaching in their area of expertise are not rewarded for their efforts. There is no Department of Emer-

gency Medicine at Indiana's medical school to convey such faculty titles.

Through the efforts of Doctor James C. Dillon, Associate Professor of Medicine (Cardiology) at Indiana and Chairman of the state's Emergency Medical Services Commission, an abbreviated emergency medical technician (EMT) course in pre-hospital emergency care was included in the freshman medical student curriculum statewide last year. A formal course involving in-hospital emergency medicine taught by specialists in emergency medicine does not exist, however, on the medical center campus—nor does a residency in emergency medicine. Indiana's only residency training program in Emergency Medicine is located at Methodist Hospital (Indianapolis).

The physician in Emergency Medicine is in part the specialist in Available Medicine. He provides

TABLE 3. EMERGENCY TEACHING IN INDIANA^{a,3}

	Number	% ^b
Emergency Physicians Teaching Medical Students	140	92
Emergency Physicians Teaching Interns	84	55
Emergency Physicians Teaching Residents	64	42
Total Indiana Emergency Physicians Teaching—All Categories	152	100
Indiana ACEP Members Teaching—All Categories	125 ^c	82

Footnotes: a. Data based on 41% return on survey, December 1979.

b. Percentage of total physicians teaching (line four).

c. Represents 51% of Indiana ACEP membership (December 1979).

the availability of medical care in a sophisticated medical setting the public demands and requires 24 hours a day. He is also though, and more importantly, the specialist in Emergency Medicine—the individual who must be able to stabilize, treat and/or triage all acute problems regardless of subspecialty orientation as they present to the emergency department. He is the specialist who is able to manage multiple emergent problems in many different patients under the constraints of cost and time, without the benefit of prior knowledge of the patient, and often without the benefit of tests and procedures which must be scheduled in advance or which cannot be accomplished in less than one to two hours. The emergency physician has only one shot at the diagnosis.

If he misses, the patient may live or die; but in either case the patient will usually not return to the office—the emergency department—so the physician can have a second chance at the real diagnosis.

Until physicians become available to their patients 24 hours a day, until at least one specialist in each specialty area is available in every hospital classified by the Joint Commission for Hospital Accreditation (JCAH) in Emergency Services as Level I or Level II, until all patients have a private physician, or until emergency visits cease to occur, emergency physicians and Emergency Medicine will have their place in medicine along side, not above or below, the other 22 recognized medical specialties.³

A fact recognized nationally is that Emergency Medicine is the

23rd recognized medical specialty. This fact has been recognized in Indiana with ISMA's Section on Emergency Medicine and the Indiana Chapter of ACEP, 244 strong and the nation's seventh largest state ACEP chapter.

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6. Personal communication, Indiana State Medical Association.



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EDITORIALS

Second Opinions: Useful or Worthless?

CONTINUED FROM PAGE 352

duces an element of distrust on the part of the patient, and in the process offers little advantage to either party.

If the second opinion coincides with the first, the tendency is to consider it a waste of time.

If the second opinion denies the first opinion, it is self evident that one of the opinions is wrong. Which one? The uncertainty becomes compounded and can be resolved possibly by a third opinion, which may introduce a three-way choice for the patient.

Certainly, a bureaucracy that proposes and promotes second opinions as a means of decreasing the cost of medical care should be classified as being uninstructed and inexperienced in the mode of human behavior and the competence of medical practice.

The National Second Opinion Program of the HEW began in 1978. Despite nationwide publicity, which is reported to have cost \$150,000, only 6,400 persons called the toll-free "hotline" phone to obtain names and phone numbers of physicians willing to give second opinions.

Last summer HEW mailed out 36 million promotional leaflets on the Second Opinion Program. Now, in spite of attracting only 6,400 calls last year, the 1980 campaign is budgeted for \$250,000. There also is a \$1 million contract with a research firm to study the effectiveness of second surgical opinion programs.

This is a lot of money to spend in promoting a program which, if it is any good at all, would by now be a going concern.

Since HEW originated the idea, and particularly since HEW has actively promoted it, HEW should also spend some money to follow-up those patients who had a second opinion and chose not to follow their first opinion. It would be interesting and educational to find how many in this group eventually were obliged by progress of symptoms to undergo the operation originally spurned. And it would be educational although tragic to discover how many did not live long enough to have a second chance at operation.

Most of the discussion on second opinions is written in such a way as to indicate that the second opinion is the correct one. This is a dangerous assumption. Between two divergent opinions there is no way to discern the right one.

Second opinions that are sought voluntarily by patient or physician are useful. They always have been encouraged by all concerned and should be continued on that basis. The voluntary nature of this type of consultation produces an atmosphere in which differences may merge into a helpful decision.

Second opinions that are mandated by government or insurance company decree lack the congeniality of the voluntary. They complicate the problem. They increase the expense.

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Use in Nursing Mothers. Because of the higher risk of antihistamines for infants generally and for newborns and prematures in particular, antihistamine therapy is contraindicated in nursing mothers.

Use in Lower Respiratory Disease. Antihistamines should NOT be used to treat lower respiratory tract symptoms including asthma.

Antihistamines are also contraindicated in the following conditions: hypersensitivity to azatadine maleate and other antihistamines of similar chemical structure; monoamine oxidase inhibitor therapy (See DRUG INTERACTIONS Section).

WARNINGS Antihistamines should be used with considerable caution in patients with narrow angle glaucoma, stenosing peptic ulcer, pyloroduodenal obstruction, symptomatic prostatic hypertrophy, bladder neck obstruction.

Use in Children. In infants and children especially, antihistamines in overdosage may cause hallucinations, convulsions, or death.

As in adults, antihistamines may diminish mental alertness in children. In the young child, particularly, they may produce excitation.

OPTIMINE TABLETS ARE NOT INTENDED FOR USE IN CHILDREN UNDER 12 YEARS OF AGE.

Use in Pregnancy. Experience with this drug in pregnant women is inadequate to determine whether there exists a potential for harm to the developing fetus.

Use with CNS Depressants. Azatadine maleate has additive effects with alcohol and other CNS depressants (hypnotics, sedatives, tranquilizers, etc.).

Use in Activities Requiring Mental Alertness. Patients should be warned about engaging in activities requiring mental alertness, such as driving a car or operating appliances, machinery, etc.

Use in the Elderly (approximately 60 years or older). Antihistamines are more likely to cause dizziness, sedation, and hypotension in elderly patients.

PRECAUTIONS Azatadine maleate has an atropine-like action and, therefore, should be used with caution in patients with: a history of bronchial asthma, increased intraocular pressure, hyperthyroidism, cardiovascular disease, hypertension.

DRUG INTERACTIONS MAO inhibitors prolong and intensify the anticholinergic (drying) effects of antihistamines.

ADVERSE REACTIONS The most frequent adverse reactions are underlined.

General: Urticaria, drug rash, anaphylactic shock, photosensitivity, excessive perspiration, chills, dryness of mouth, nose, and throat.

Cardiovascular System: Hypotension, headache, palpitations, tachycardia, extrasystoles.

Hematologic System: Hemolytic anemia, thrombocytopenia, agranulocytosis.

Nervous System: Sedation, sleepiness, dizziness, disturbed coordination, fatigue, confusion, restlessness, excitation, nervousness, tremor, irritability, insomnia, euphoria, paresthesias, blurred vision, diplopia, vertigo, tinnitus, acute labyrinthitis, hysteria, neuritis, convulsions.

Gastrointestinal System: Epigastric distress, anorexia, nausea, vomiting, diarrhea, constipation.

Genitourinary System: Urinary frequency, difficult urination, urinary retention, early menses.

Respiratory System: Thickening of bronchial secretions, tightness of chest and wheezing, nasal stuffiness.

OVERDOSAGE Antihistamine overdosage reactions may vary from central nervous system depression to stimulation. Stimulation is particularly likely in children. Atropine-like signs and symptoms (dry mouth, fixed, dilated pupils; flushing, and gastrointestinal symptoms) may also occur.

If vomiting has not occurred spontaneously, the patient should be induced to vomit. This is best done by having him drink a glass of water or milk after which he should be made to gag. Precautions against aspiration must be taken, especially in infants and children.

If vomiting is unsuccessful, gastric lavage is indicated within three hours after ingestion and even later if large amounts of milk or cream were given beforehand. Isotonic and ½ isotonic saline is the lavage solution of choice.

Saline cathartics, such as milk of magnesia, draw water into the bowel by osmosis and therefore are valuable for their action in rapid dilution of bowel content.

Stimulants should not be used.

Vasopressors may be used to treat hypotension.

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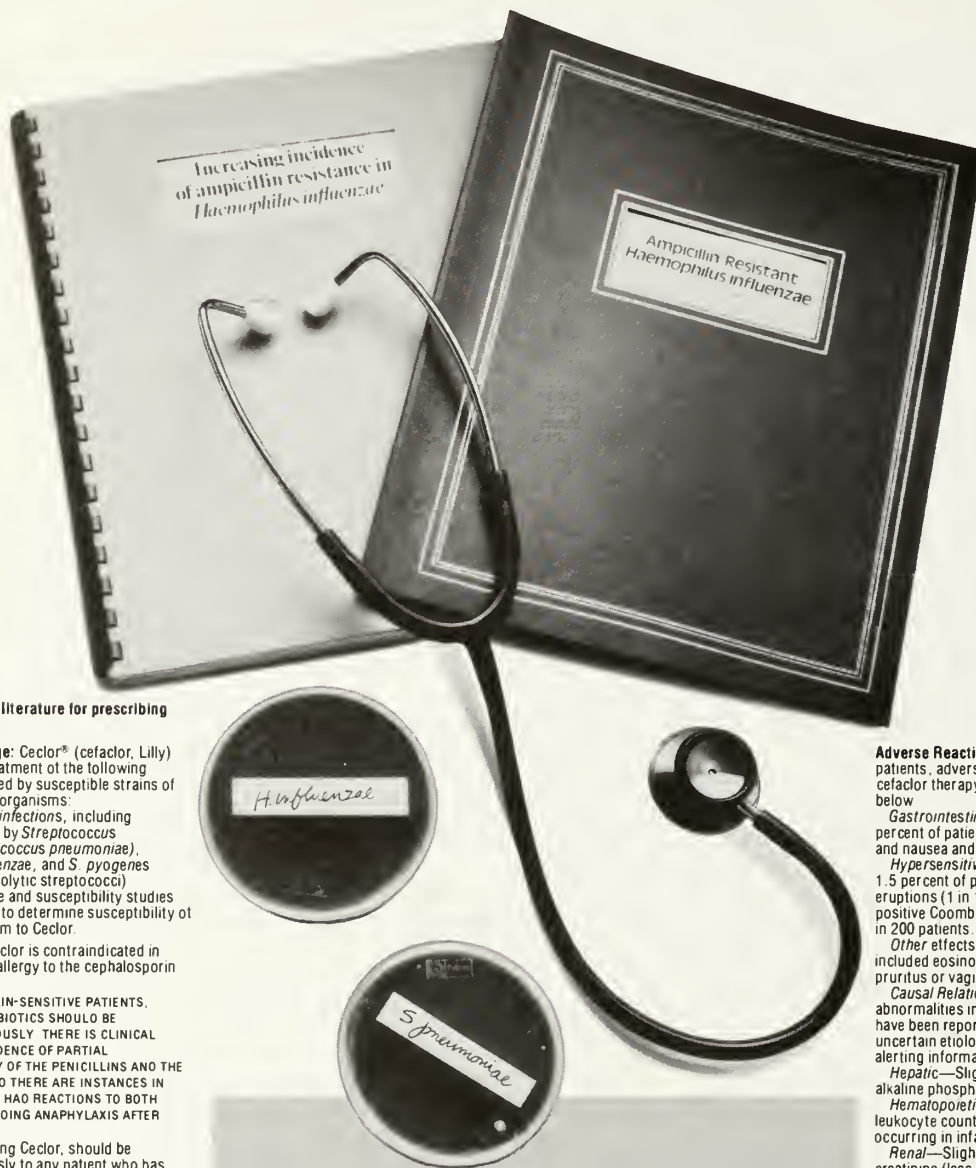


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An added complication... in the treatment of bacterial bronchitis*



Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cefclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci). Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefclor.

Contraindication: Cefclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS TO BOTH DRUG CLASSES (INCLUDING ANAPHYLAXIS AFTER PARENTERAL USE).

Antibiotics, including Cefclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefclor.⁷

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Adverse Reactions: In clinical studies in 1493 patients, adverse effects considered related to cefaclor therapy were uncommon and are listed below.

Gastrointestinal symptoms occurred in about 2.5 percent of patients and included diarrhea (1 in 70) and nausea and vomiting (1 in 90).

Hypersensitivity reactions were reported in about 1.5 percent of patients and included morbilliform eruptions (1 in 100). Pruritus, urticaria, and positive Coombs tests each occurred in less than 1 in 200 patients.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

*Causal Relationship Uncertain—*Transitory abnormalities in clinical laboratory tests results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

*Hepatic—*Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

*Hematopoietic—*Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

*Renal—*Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[070379#]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefclor® (cefaclor) is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.
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The Biopolitics Of Choking

Guest Editorial

HARRY L. GIBBONS, M.D.
Salt Lake City, Utah

THE HISTORY OF TREATMENT of the choking victim took a dramatic turn just a few years ago with the advent of the Heimlich Maneuver. Then suddenly, other methods, including back blows, (which had been in use for years with equivocal results), had "scientific" evidence to support their use in competition with the obvious success, including self-administration of the Heimlich Maneuver.

It is extremely unfortunate that medical science which offers so much relief from human suffering, works so hard to preserve life and shares so willingly advances in health care, can become so encumbered by petty differences that many of us will to ignore success and facts, and reverse and subvert the very goals to which physicians are dedicated.

Choking on food and other objects in the past has been listed as the sixth leading cause of accidental death. It results in over 3000 fatalities per year in the United States. However, as consistent treatment has become available, it is apparent this has probably occurred far more frequently than was previously suspected.

As the result of the death of a prominent citizen in the Salt Lake Valley from choking on food and subsequent saving of a life of another prominent citizen, by the use of the Heimlich Maneuver, the Health Department became deeply involved in teaching the Heimlich Maneuver. Apparently Salt Lake Valley was one of the first communities in the country to follow such a program and rapidly accumulated data on numerous successful saves using the Heimlich Maneuver.

Because of this experience the writer was invited to a special meeting at the American Red Cross in Washington, D.C., where the treatment

protocol was to be determined that the Red Cross would follow. At that meeting it became readily apparent to me that the Heimlich Maneuver was the only treatment method with consistent successful results.

Although "research" was presented indicating (using a small number of anesthetized baboons with attendant muscle relaxation) throat obstructions could be loosened by back blows, in the writer's opinion, the consensus was that the abdominal thrust, (which I prefer to call the Heimlich Maneuver), was far more effective than anything else that had ever been used. The writer left that meeting with the understanding that that would be the written result of the meeting. Also, the Red Cross educational advisor strongly recommended that the adopted treatment protocol be kept simple.

Sometime later the document which was disseminated to the attendees called for back blows prior to the use of the abdominal thrust and this was to be followed by finger swipes. The writer objected, in writing, to the American Red Cross, and was not contacted again regarding the matter. Later the Red Cross, based on recommendations by the National Academy of Sciences, (which reviewed the data of the anesthetized baboons being treated with back blows), and other documents of marginal significance, publicized and rigidly followed a program to administer back blows prior to the use of the abdominal thrust. There was no attempt to provide research or comparative data collection.

The Red Cross has even gone to the expense of producing extensive defensive materials emphasizing that back blows should be used; however, it is quite apparent that the consultants utilized in one major Red Cross presentation do not agree among themselves on how, why or where,—only that all possible treatments should be used.

Although not officially taught by the Red Cross, it has been disseminated in our community that if back blows are good, we should use them for self-administration also. The author has observed a Red Cross volunteer nurse teach the following method of self-administration: "Stand in a doorway, bend forward at the waist, and then throw the upper body against the door frame." There are no instructions on how to keep the head from striking the door frame, or on how to keep the head from striking the door frame, or on how to treat the ensuing concussion. In contrast,

CONTINUED ON PAGE 364

The author is a member of the Editorial Board of the USMA Bulletin, Utah State Medical Association, in which this editorial appeared in March 1980. Reprinted with permission.

CANCER-RELATED CHECKUPS:

Guidelines for Site Tests, Examinations

THE AMERICAN CANCER SOCIETY has modified its recommendations to the public about checkups for the early detection of cancer. The recommended changes are based on new scientific and medical information about the onset and growth of various cancers. The changes are also based on the risks and effectiveness of the test and procedures available to detect cancers as well as costs and availability.

The guidelines result from an 18-month study by ACS expert committees and task forces on the various cancer sites. Their report was approved by the Society's Board of Directors on recommendation of the Service and Rehabilitation, Professional Education, and Medical and Scientific Committees. In addition, the recommendations were revised by the Colon and Rectum Task Force, the Breast Task Force and a special committee of obstetricians and gynecologists.

In reviewing cancer tests and making current recommendations the Society had four main concerns: 1) that each test or procedure is medically effective in reducing morbidity or mortality; 2) medical benefits outweigh any possible risks; 3) costs are reasonable in relation to expected benefits; and 4) the recommendations are easily implemented.

Given these concerns, the Society has determined, for each of the

major types of cancer, the age and frequency of examinations that will deliver essentially the same health benefits to the public as the previous ACS recommendations. The Society feels that this will result in greatly reduced inconvenience, risk and cost to the patient. Hopefully, greater numbers of adults will be motivated to protect themselves against this disease. Following is a summary of guidelines:

Colon and Rectum: The Society recommends proctosigmoidoscopic examinations for colorectal cancer at three- to five-year intervals after the age of 50, provided negative examinations have been recorded for two consecutive years. Previously, the Society had urged annual proctosigmoidoscopic examinations for everyone past 40. The guaiac slide test for hidden blood in the stool, an indicator of unsuspected intestinal bleeding from any cause, now is recommended annually for persons over the age of 50 instead of 40. However, annual digital rectal examinations continue to be recommended from age 40 on.

Cervix: Instead of urging that all women obtain annual Pap tests for cervical cancer, the Society now advises that women over the age of 20, and those under 20 who are sexually active, have the test at least every three years, but only after they have had two negative Pap tests a year apart. *A pelvic examination is recommended every three years from age 20 to 40 and annually thereafter.*

Breast: The ACS recommends that women 20 to 40 have a breast physical examination every three years; those over 40 should be examined every year. The Society continues to urge that all women past the age of 20 examine their own breasts once a month, *and counsels annual mammography as a means of discovering early breast cancer in women over 50.* A baseline mammogram is recommended between the ages of 35 to 40. Women between 40 and 50 should consult their personal physician about the need for mammography in their individual cases.

Lung: Annual chest x-rays and sputum cytology are no longer recommended for asymptomatic people for detecting lung cancer. So far, there are no long-term studies that prove that finding lung cancer by these methods has reduced overall mortality—even though some tumors may be detected earlier. The Society continues to emphasize programs of lung cancer prevention that will stress the health advantages of quitting smoking and not starting to smoke cigarettes. The Society formerly had recommended chest x-rays for heavy smokers and others considered to be at high risk.

The Society is aware of the extremely important research projects underway at Memorial-Sloan Kettering Cancer Center, the Mayo Clinic, and the Johns Hopkins Hospital. The Society urges all patients who participate to continue to receive their examinations and not leave these ongoing programs.

Copies of the new ACS Guidelines, upon which this article is based, are available from the Indiana Division, American Cancer Society, Inc., 4755 Kingsway Dr., Suite 100, Indianapolis, Ind. 46205.

SUMMARY

The Society recommends the following protocol for the early detection of cancer in asymptomatic persons.

Test or Procedure	Sex	New Recommendation		Previous Recommendation
		Population	Frequency	
Chest x-ray		—not recommended—		high risk persons, annually ¹
Sputum cytology		—not recommended—		not recommended
Sigmoidoscopy	M&F	over 50	every 3-5 years; after 2 neg. exams 1 year apart	persons over 40 annually
Stool guaiac slide test	M&F	over 50	every year	persons over 40 annually
Digital rectal examination	M&F	over 40	every year	same
Pap test	F	20-65; under 20 if sexually active	at least every 3 years; after 2 neg. exams 1 year apart; More frequently in high-risk women. ⁴	annual
Pelvic examination	F	20-40 over 40	every 3 years every year	annual same
Endometrial tissue sample	F	at menopause women at high risk ²	at menopause	same
Breast self-examination	F	over 20	every month	same
Breast physical examination	F	20-40 over 40	every 3 years every year	annual same
Mammography	F	between 35-40 under 50 over 50	baseline consult personal physician every year	{ no policy policy related only to BCDDP
Health counseling and cancer checkup ³	M&F M&F	over 20 over 40	every 3 years every year	"periodic"

¹ persons over 40 who smoke or are exposed to other lung carcinogens.

² history of infertility, obesity, failure of ovulation, abnormal uterine bleeding, or estrogen therapy.

³ to include examination for cancers of the thyroid, testicles, prostate, ovaries, lymph nodes, oral region, and skin.

⁴ early age at first intercourse, multiple sex partners.

When these projects are completed, the Society will review and evaluate the findings, and determine whether its recommendations should be changed in regard to lung cancer.

Checkups: The Society now recommends annual cancer-related checkups only for asymptomatic men and women past the age of 40, and checkups every three years for those between 20 and 40.

High Risk Exceptions: The Society report states that more frequent examinations may be needed for persons considered to be at higher-than-normal risk for some cancers. High risk groups for breast cancer generally include women with *personal or family histories of breast cancer*. High risk indicators for cervical cancer *include early age at first intercourse and multiple sexual partners*. For women at high risk of endometrial cancer, the Society continues to urge taking a tissue sample at menopause. High risk in this case is defined as a history of *infertility, obesity, failure of ovulation, abnormal uterine bleeding, or estrogen therapy*. Persons at high risk of colorectal cancer include those with familial polyposis, Gardner's syndrome, ulcerative colitis, a

history of polyps or prior colon cancer, or a family history of cancer of the colon or rectum.

Points of Emphasis: The new guidelines apply only to checkups specifically designed to uncover early cancer, and do not refer to examinations for the detection of other diseases. The recommendations are for people without symptoms, since the Society emphasizes that those with symptoms or signs suggestive of cancer should immediately seek medical help.

The Society will reinforce its new recommendations with an intensive public and professional education campaign that will urge every adult to "Talk with your doctor and ask how these guidelines relate to you." The revised guidelines are intended to help individual physicians and patients select the early detection procedures that best meet the patient's needs.

This is not a mass screening concept. Each person has his or her own distinctive health needs. Personal histories, risk factors, objectives and budgets are different for all people, so no single recommendation can be fitted to all. The recommendations of each patient's doctor should never be ignored.

For example, gynecologists, who are essentially the primary physicians for young women in the reproductive age group and who see women in connection with pregnancy, family planning or sexually transmitted diseases, may have special reasons for modifying the guidelines to suit the needs of individual patients. In other disciplines, similar considerations will apply.

In ACS terminology, a cancer-related checkup includes, in addition to the tests and procedures outlined above, health counseling and specific examinations for possible cancers of the lymph nodes, thyroid, mouth, skin, ovary, prostate and testes.

Because the new recommendations are intended for people without symptoms, a physician should always be consulted if any of cancer's well-known seven warning signals appear. These include change in bowel or bladder habits, a sore that does not heal, unusual bleeding or discharge, thickening or lump in the breast or elsewhere, indigestion or difficulty in swallowing, obvious change in a wart or mole, and nagging cough or hoarseness.

The Biopolitics of Choking . . .

CONTINUED FROM PAGE 361

the Heimlich Maneuver can be, and has been on numerous occasions, safely self-administered.

The physician members of the Utah State Emergency Medical Services Council Executive Committee unanimously recommended that the Heimlich Maneuver without the backslap should be the state standard.

Recently one of the consultants previously utilized by the American Red Cross recommended that the order be reversed; that is, for at least a 12-18 month period the Heimlich Maneuver, or

as the Red Cross prefers to call it, the abdominal thrust, be utilized first to attempt finally to collect data. This, in the opinion of the writer, would solve the problem, since if anything is going to be successful, it will be the Heimlich Maneuver. The Red Cross is resisting this because of the expense involved in promulgating the ill fated procedure now taught, but in my opinion it's only a matter of time until backblows are entirely abandoned. It is extremely unfortunate that so much time has been and will be wasted and that informational material cost is placed before adequate data collection and probably before the cost of lives.

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Inpatient Discharge Planning

JACQUELINE BERNS, A.C.S.W.
Indianapolis

MOST HOSPITAL PATIENTS with changed physical condition or debilitating illness need assistance through a highly complex maze of post-hospital care. The expansion of medical knowledge in this century has improved health care to patients and has many consequences for hospitals.

Coordinating a post-hospital discharge in order that comprehensive services can be provided assures continuity of care. Effective discharge planning assists bed utilization when patients are released from the hospital bed to a less intensive level of care. Retroactive denial of funds to the hospital or physician third-party payers due to patients' inappropriate length of stay is decreased by discharge programs. Uncertainties and stress also are decreased by planning.

Coordination of services to some patients at discharge is undertaken by nurses or social workers. However, for the majority of patients, assistance at discharge may be missing in its entirety. Contrasted with the attention paid to the patient on admission, orders at discharge for a patient's referral to community resources are notable for their absence. A discharged patient's continuing care needs can be appropriately coordinated by medical social workers or those nurses trained in full discharge planning. In small hospitals the need for discharge planning may be the primary reason a social worker is first hired. Bachelor of Social Work or Nursing graduates, when appropriately supervised, exhibit professional skills for coordinating discharge services.

Adjustment for the patient after hospitalization may include decreased physical and mental well-being, changes in family responsibilities, a different lifestyle, employment problems and financial difficulties as a result of illness or injury. Discharge often oc-

curs when the patient is only partially independent. Improved post-hospital care requires the cooperation of physicians, the family, nurses and community health agencies. The medical social worker and discharge coordinator are agents with this inter-disciplinary effort.

The following criteria can be used to identify patients who are likely to need discharge assistance due to a combination of problems: the elderly who live alone, the chronically ill, the permanently disabled, the transient patient, the teenage mother, the mentally retarded, the patient with multiple illnesses and the patient having radical surgery. By screening these patients, services relating to the consequences of a medical problem can be provided.

Expanded information and actual referral services are required by some patients, with guidance from their physicians. Screening of an inpatient is desirable a week in advance of the estimated time of discharge. If the patient is approached by the discharge coordinator/social worker too early, the family may react negatively, with the impression their relative is being pushed out of the hospital. If referrals of patients are made 10 minutes before discharge, logical help with problems becomes improbable and the discharged patient may soon be back in the hospital. Medicare patients, the old and the handicapped are sometimes categorized as most in need of discharge planning services but equal access to disposition planning should be available to all patients and families.

Some patients do not wish to leave their hospital beds. The family hesitates or believes the patient can be hospitalized as long as they desire if they have hospital insurance. The continuing care/discharge coordinator explains to patients and their families the regulations governing Medicare/Medicaid hospital stays. Other hospital insurance is terminated when the patient no longer needs hospital care but the medical social worker can suggest alternative sources for health care at discharge.

The process of assistance with discharge plans by a medical social worker/discharge planner includes the following steps:

The author is Director of Social Service, Community Hospital, 1500 N. Ritter Ave., Indianapolis, Ind. 46219.

- The hospital chart is read within one working day of a referral.

- The patient is interviewed and his or her reaction to discussion of discharge is recorded on the chart.

- Social and medical information provided by the patient or physician is noted.

- The patient's spouse, relatives or friends are contacted.

- Information is entered in the medical chart on the progress of planning. The charge nurse and physician are kept informed of the progress of discharge plans for the patient.

- If patients are physically unable to handle finances (pay bills, endorse income checks) the patient's consent is sought to have a spouse, friend or relative appointed with power of attorney. The patient who is mentally incompetent may need a court-appointed guardian.

When nursing home placement is considered, the discharge coordinator must know the patient's diagnoses and determine the need for either skilled or intermediate nursing care. In addition, the charge nurse or physician can supply the following information:

- Is patient to receive special diet, decubital care, physical, occupational or speech therapy; treatment by respirator or restraints?

- How many self-help skills does the patient have—bathing, feeding, toileting?

- Are medications taken other than orally?

Answers to these questions will help the discharge coordinator, the family and nursing home administrator find a nursing home bed at an appropriate level of care.

The discharge planner offers help to family members with the feelings entailed by placing one's parent outside his or her home. Families are encouraged to check out one or more nursing homes as close and convenient to their own home as possible. The discharge planner's knowledge of locations, therapies and policies of Nursing Homes assists the family's decision making. If necessary, the patient's name is placed on a waiting list at two or three facilities. If the patient's personal physician will not attend the patient at the nursing home, the facility's physician is asked to follow the patient medically. Transfer orders to the nursing home must accompany every patient discharged from a hospital.

For discharge with nursing care at home, a discharge coordinator talks to the patient's nurses, the doctor, the patient and the family. Then determination is made as to the full range of home care needed and the family's ability to sustain and afford professional care in the home. Home care as an alternative to a nursing home involves careful assessment of the resources needed and available to the patient.

The Visiting Nurse Association frequently can adjust fees according to ability to pay, offering nursing care by the hour. Community Health Nursing is a public health agency and a resource for nursing visits that may not involve nursing procedures. Their free service is educational, supportive and concerned with the home environment. Proprietary nursing agencies have no provision for adjusted fees but may be certified to receive Medicare or Medicaid payments. Twenty-four hour care is available from a live-in LPN or aide, from a medical employee registry or from a hospital's homemaker/home health aide service. Part-time sitters or companions can be provided by local agencies such as "Senior Enterprises." The hospital Social Service Department may have a list of individuals willing to live in the patient's home to give minimal health care. These homemakers are not always interviewed by a discharge coordinator but have been recommended by other patients or physicians with good results.

Transfer to a rehabilitation unit is considered for inpatients with severe injuries or chronic illness, whose medical condition has stabilized. These patients have potential for achieving a degree of mobility and independence. For stroke and spinal-cord injured patients, referral to an inpatient rehabilitation center or outpatient visits to a rehabilitation clinic should be carefully planned by all professional personnel.

When a patient needs to be transferred to a state mental hospital, a voluntary admission or an involuntary commitment is arranged with cooperation from relatives and physicians. Knowledge of these facilities helps the patient and family accept the recommendation. The concept of hospice care for the terminally ill, where skilled techniques help patients in the process of dying, fills an existing gap in the present health care system but exists only in some communities.

For patients such as the frail elderly discharged to their homes, referrals should be to Senior Citizens Day Care programs, Telecare and Meals on Wheels. Neighborhood health centers, protective services, nutrition and food stamp programs may be utilized. For the psychiatric patient a "halfway house" or day-therapy program may be implemented following the physician's recommendation. Assisting with arrangements for hospital outpatient therapy, dietary instruction or educational input by specialized agencies and personnel are effective follow-through tasks of a discharge coordinator.

Who Pays for Continuing Care?

Health insurance policies rarely cover the cost of professional care in the home or for a nursing home. If the family is to pay the costs themselves, they often do not know the charges to be incurred. In Indiana, typical charges for care at home are:

Registered Nurses	\$12 per hour
Licensed Practical Nurses	\$ 9 per hour
Nurse's Aides	\$ 6 per hour
Health Aides (live in)	\$60 per 24 hours

Nursing home rates are:

Skilled Nursing Care .	\$1,000-\$1,500 per month
Intermediate Care	\$ 850-\$1,000 per month

Charges for a private room, doctor's visits, therapies, medication, a telephone, a private duty nurse and personal care items may be additional expenses for a family to consider. A Medicare Supplement Plan may pay some of these charges.

Medicare can pay for up to 100 health care visits in the home, but a skilled nursing level of care for the patient is a prerequisite. Services are part-time skilled nursing, usually limited to one hour daily, health aides (up to 20 hours a week), PT, OT and Speech Therapy if provided by a licensed agency.

In a nursing home, Medicare covers patients who need skilled nursing care or rehabilitation services, not intermediate or custodial care. Twenty days full coverage may be provided in each benefit period with the possibility of 80 additional covered days with a \$20 daily deductible. The patient must enter the extended care facility (nursing home) after a minimum three days of hospitalization.

Medicaid is for low-income patients who may not be able to afford skilled or intermediate care in a nursing home, any deductible portion of covered charges, care in the

home as prescribed by a physician, or other medical expenses. It also should be considered for the patient who soon will exhaust his savings. It is payable in all states (except Arizona) to people entitled to Supplemental Security Income or Aid for Families with Dependent Children. Thirty-two states, but not Indiana, also authorize Medicaid to people whose income is below a certain level.

The Medicaid patient can have assets up to \$1,500 monthly. In Indiana in 1979 (September), the maximum for savings was raised to meet this standard. The patient may need to find out the cash surrender value of life insurance policies, which are counted as an asset; the value of a home and car usually are not counted as assets. Explanation of any claim by the state is reassuring to the patient: If there is ownership of homestead property, a claim for reimbursement is made only if the applicant is over 65 and only at the death of the spouse/owner or dependents. If the patient owns real estate which is not lived in, the patient will be required to sell it and use the assets before Medicaid services are provided.

Conclusion

Skills in discharge coordination and the detailed knowledge needed for individual patients to complete their recovery from illness often are not found in hospitals. Empathic understanding of patients' and families' discharge dilemmas is a social work skill that, when linked with resource knowledge, is the basis for a patient's use of community-based health care systems. Discharge coordination advances the concept of a holistic approach to the patient. Defining the process and upgrading professional competence in coordinating and delivering discharge services results in a successful intervention method that can significantly reduce patient and family trauma and is a much needed service to both hospitals and patients.

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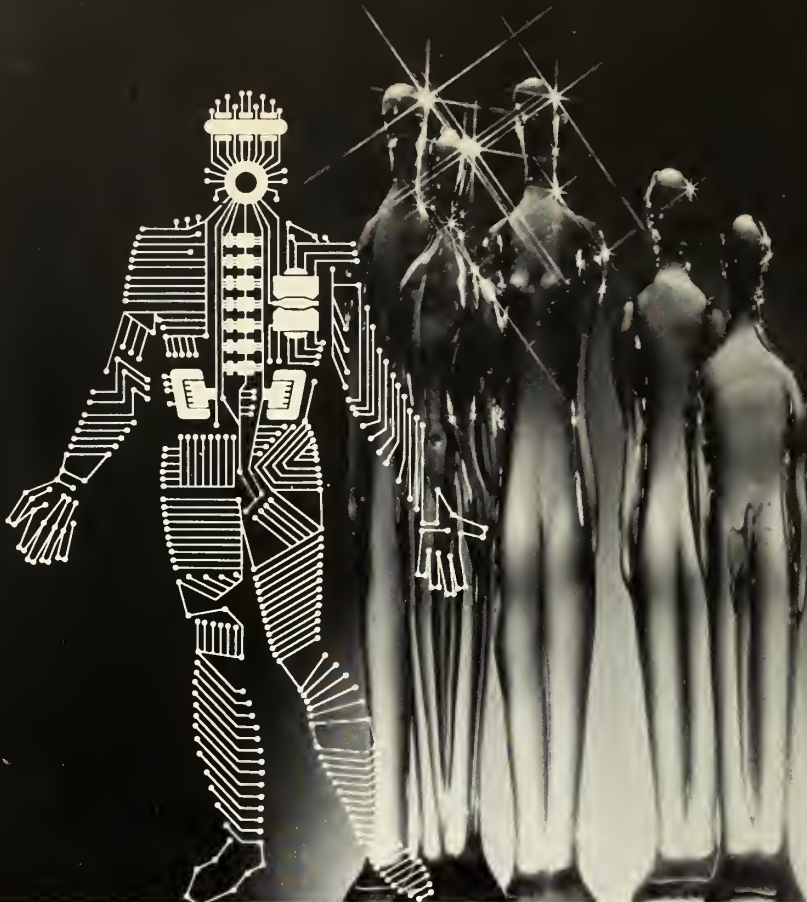
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Usage in Pregnancy: In view of embryotoxic findings in animals, and since information on possible adverse effects in pregnant women is limited to uncontrolled clinical data, the drug is not recommended in women who are or may become pregnant unless the potential benefits outweigh the potential risk to mother and fetus.

Usage in Children: No clinical experience is available with the use of Catapres (clonidine hydrochloride) in children.

Precautions: When discontinuing Catapres (clonidine hydrochloride), reduce the dose gradually over 2 to 4 days to avoid a possible rapid rise in blood pressure and associated subjective symptoms such as nervousness, agitation, and headache. Patients should be instructed not to discontinue therapy without consulting their physician. Rare instances of hypertensive encephalopathy and death have been recorded after cessation of clonidine hydrochloride therapy. A causal relationship has not been established in these cases. It has been demonstrated that an excessive rise in blood pressure, should it occur, can be reversed by resumption of clonidine hydrochloride therapy or by intravenous phenolamine. Patients who engage in potentially hazardous activities, such as operating machinery or driving, should be advised of the sedative effect. This drug may enhance the CNS-depressive effects of alcohol, barbiturates and other sedatives. Like any other agent lowering blood pressure, clonidine hydrochloride should be used with caution in patients with severe coronary insufficiency, recent myocardial infarction, cerebrovascular disease or chronic renal failure.

As an integral part of their overall long-term care, patients treated with Catapres (clonidine hydrochloride) should receive periodic eye examinations. While, except for some dryness of the eyes, no drug-related abnormal ophthalmologic findings have been recorded with Catapres (clonidine hydrochloride), in several studies the drug produced a dose-dependent increase in the incidence and severity of

The usual starting dose of Catapres is 0.1 mg at breakfast and 0.1 mg at bedtime. Some patients may benefit from a starting dose of 0.1 mg at bedtime.

Usual daily dose range—0.2—0.8 mg

Maximum daily dose—2.4 mg
Doses as high as this have rarely been employed.

For optimal results, the dose of Catapres must be adjusted according to the patient's individual blood pressure response.

spontaneously occurring retinal degeneration in albino rats treated for 6 months longer.

Adverse Reactions: The most common reactions are dry mouth, drowsiness and sedation. Constipation, dizziness, headache, and fatigue have been reported. Generally these effects tend to diminish with continued therapy. The following reactions have been associated with the drug, some of them rarely. (In some instances an exact causal relationship has not been established.) These include: Anorexia, malaise, nausea, vomiting, parotid pain, mild transient abnormalities in liver function tests; one report of possible drug-induced hepatitis without icterus and hyperbilirubinemia in a patient receiving clonidine hydrochloride, chloralhydrate and papaverine hydrochloride. Weight gain, transient elevation of blood glucose, or serum creatine phosphokinase; congestive heart failure, Raynaud phenomenon; vivid dreams or nightmares, insomnia, other behavioral changes; nervousness, restlessness, anxiety and mental depression. Also rash, angioneurotic edema, hives, urticaria, thinning of the hair, pruritus not associated with a rash, impotence, urinary retention, increased sensitivity to alcohol, dryness, itching or burning of the eyes, dryness of the nasal mucosa, pallor, gynecomasia, weakly positive Coombs' test, asymptomatic electrocardiographic abnormalities manifested as Wenckebach period or ventricular trigeminy.

Overdosage: Profound hypotension, weakness, somnolence, diminished or absent reflexes and vomiting followed the accidental ingestion of Catapres (clonidine hydrochloride) by several children from 19 months to 5 years of age. Gas lavage and administration of an analeptic and vasopressor led to complete recovery within 24 hours. Tolazoline in intravenous doses of 10 mg at 30-minute intervals usually abolishes all effects of Catapres, (clonidine hydrochloride) overdosage.

How Supplied: Catapres, brand of clonidine hydrochloride, is available as 0.1 mg (tan) and 0.2 mg (orange) oval, single-scored tablets in bottles of 100 and 1000. Also available as 0.3 mg (peach) oval, single-scored tablets in bottles of 100.

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To obtain Category 1 credit for this month's article, complete the quiz on Page 399.



Breast-Feeding the Newborn

PAMELA K. LEMONS, R. N., M.S.N.¹
MARJORIE KOCHANZKY, R.N., M.S.N.²
JAMES A. LEMONS, M.D.³
Indianapolis

THE COMMITTEE on Nutrition of the American Academy of Pediatrics recently endorsed breast-feeding as the preferred method of feeding the normal full term infant, unless there are specific contraindications or the attempt to breast-feed is unsuccessful.¹ This recommendation reflects a resurgence of interest in breast-feeding throughout the country.² Not only are more mothers desirous of suckling their normal babies, but frequently they are intent upon providing their premature or sick newborn with their own milk. There is thus an increased need for professionals to be familiar with breast-feeding. As much folklore still persists, this review is written

as a practical guide to those involved with counseling the new or expectant mother concerning breast-feeding.

POTENTIAL ADVANTAGES OF BREAST-FEEDING

Human milk is still regarded as the standard for neonatal/infant nutrition. Standard formulas simulate the basic composition of breast milk, although many factors present in human milk have either not yet been identified or cannot be reproduced at this time. Breast milk thus remains unique, providing general and specific advantages to the baby, as depicted in *Table 1*. Detailed discussions of these characteristics of human milk are

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available in the literature, and are recommended to the reader.³⁻⁵ Suffice to say that the major advantages of breast milk for the newborn are felt to reside in the host defense properties of the milk (which may decrease infectious morbidity), in the psychological aspects of maternal-infant bonding (successful lactation is a very pleasant and positive experience for most mothers and infants), and in the greater digestibility of the milk (providing essentially a balanced intake of all nutrients for the term infant).

CONTRAINDICATIONS

There are relatively few contraindications to breast-feeding. The most obvious is the desire of the mother not to breast-feed. However, caution must be expressed, as most mothers who decide not to nurse their baby do so in a passive rather than active manner. They simply are not informed about breast-feeding, and more or less drift into a non-decision to bottle-feed their baby. However, if a mother expresses a firm desire not to nurse her baby (and is properly informed), then this decision must be respected and supported in a positive fashion. Formulas are generally available that will support normal growth and nutrition for her baby without recognized untoward effects.

Other contraindications to breast-feeding may include congenital anomalies in the newborn that preclude normal suckling or digestion, severe maternal disease (tuberculosis), or long-term maternal ingestion of medications that may adversely affect the infant. Although almost all drugs taken by the mother are secreted in breast milk, relatively few reach significant concentrations in the milk to have a demonstrable effect on the baby.⁶ Temporary contraindications to breast-feeding are listed in *Table*

TABLE 1

Potential Beneficial Properties of Human Milk and Breast Feeding

- A. Nutritional—generally well absorbed and appropriately balanced
 - 1. Efficient fat and protein absorption
 - 2. Decreased curd formation with prolonged transit time
 - 3. Adequate amounts of all known nutrients for term infant
 - 4. Increased iron absorption
 - 5. Proper calcium, phosphorus concentrations and ratio
 - 6. Increased cholesterol content (? significance)
- B. Immunological—general decreased incidence of gastrointestinal and respiratory infections
 - 1. Altered intestinal flora (*Lactobacillus bifidus*)
 - 2. Immunoglobulins (particularly secretory IgA)
 - 3. Lactoferrin, transferrin
 - 4. Lactoperoxidase
 - 5. Lysozyme
 - 6. Cellular components (macrophages, lymphocytes, neutrophils)
 - 7. Interferon
 - 8. Complement (all components)
- C. Psychological—may enhance maternal-infant bonding
- D. Miscellaneous—convenient (usually), economical, less possibility of overfeeding, rarely allergic

2. If the medications designated are used for a limited time, it may be possible for a mother to express her milk in order to maintain adequate supply and resume nursing after the course of medication is safely completed.

Other historical contraindications, such as small breasts, depressed nipples, wrong temperament, too young or too old, etc., have not been documented as valid concerns. In general, breast-feeding is possible for the majority of mothers and infants when appropriate instruction and support are available.

PREPARATION OF THE MOTHER/FAMILY

Proper breast-feeding instruction is essential if an informed decision is to be made; this is particularly important to the expectant mother

of a first child, or where family support is lacking. Ideally, the preparation should begin two to three months before anticipated delivery. Instruction may be provided individually at office visits or in groups at prenatal classes. However, the instructor must be very familiar with the practical aspects and documented facts concerning breast-feeding. If an expectant mother wants to breast-feed, it often is helpful to speak with the father or other immediate family as well to generate familiarity and support from those close to the mother. A new father may then anticipate to some degree the needs of the breast-feeding mother at home. Prenatal instruction also will permit new mothers to become familiar with their breasts and begin specific preparation if such findings as depressed nipples are present.⁷

TABLE 2
Drugs in Breast Milk*

May not be used during breast feeding— <i>definite adverse effects</i>	To be avoided when possible during breast feeding— <i>possible but often unknown risk</i>
Gold	Indomethacin
Chloramphenicol	Aspirin—regular, high dose
Tetracyclines	Sulfonamides
Nalidixic acid	Warfarin
Antineoplastic agents	Reserpine
Iodides	Corticosteroids—high dose
Antithyroid medications	Sex steroids
Ergot, Ergotamine	Diazepam
Lithium	Chloral hydrate
Radioactive drugs	Some stool softeners
Bromides	Marijuana
Prolonged alcohol	Cocaine
	Hallucinogens
	Others

*See reference #6

MILK PRODUCTION, NURSING

It is necessary to understand the anatomy and physiology of the breast and lactation process before attempting to explain how best to establish milk production.^{8,9} The breast is composed of 10-20 lactiferous duct systems composed of an alveolus (grape-like clusters of milk producing cells), the ductule, the duct, the lactiferous duct, the lactiferous sinus, ampulla, and the nipple pore.

Surrounding the alveolus are myoepithelial cells (with contractile properties). When suckling commences, proprioceptors in the areolar region are stimulated and nerve impulses are transmitted via somatic, afferent nerves to the hypothalamic area. Mediated through the hypothalamus, the anterior pituitary is then stimulated to secrete prolactin, which induces the alveoli to secrete milk. Within a three-minute period, the same stimulus causes the posterior pituitary to secrete oxytocin, resulting in smooth

muscle contractions. The myoepithelial cells then contract, causing a release of concentrated fat and protein particles into the duct system. This is referred to as the "let-down" and is a neuro-humoral reflex governed by the act of sucking.

The let-down may be experienced by the mother as a pins and needles sensation at the beginning of nursing sessions. However, it is not unusual for the mother to have no sensory awareness of a let-down response other than the appearance of milk in the first week of lactation. The mother may feel a tensing of the breasts referred to as the "draught." With a good draught, the mother may notice leaking from the opposite breast (which may be controlled by gentle pressure over the breast for one to two minutes). As her breast capacity increases, this leaking will subside. "Draught" often occurs in response to the crying of the infant, i.e., demand feedings.

The mother produces two types of milk—"fore" and "hind" milk. "Fore" milk is a milk secretion

produced at a constant rate by dialysis. It is composed of low fat and protein content, which empties into the sinuses and composes one-third of the milk volume available to the infant. The "hind" milk, secreted two to three minutes after nursing begins, is produced when oxytocin stimulates smooth muscle contraction (myoepithelial cells) causing disruption of the secretory cell membrane, thereby forcibly propelling particles into the duct system. This milk contains 4-7% fat and comprises the remaining two-thirds of the milk supply. While the infant is nursing at the first breast, mixing of hind milk and fore milk is occurring in the opposite breast. It is, therefore, beneficial to the infant to be offered both breasts at each feeding.

In the early post partum period, the infant should be allowed to nurse on a "demand" schedule, with the mother allowing the infant to suckle for approximately five minutes on each side. The colostrum that the infant receives during these sessions varies in amount from an estimated 10 to 50 cc and provides approximately 67 Kcal/100 ml. Colostrum is characterized by a relatively high ash content (including sodium, potassium and chloride) and increased concentration of immunoglobulins (particularly secretory IgA). If the infant seems hungry after these limited sessions at the breast, he or she can be supplemented with 5% glucose water or sterile H₂O until he seems content. Supplementation of the infant with formula during the early newborn period generally is not recommended, as this may decrease the frequency with which the infant will demand to be fed and may also decrease the baby's enthusiasm for suckling; subsequently, this may decrease stimulus for milk production and create significant problems as the transitional milk "comes in" at three or four days.

The stimulus for milk production occurs through the action of prolactin on the mammary alveoli, beginning from 24 hours to 96 hours post-delivery. Breast engorgement can occur during this time in both lactating and non-lactating women and is due to two factors: First, there is an increase in venous and lymphatic stasis in the surrounding breast tissue; second, there is an accumulation of milk within the alveoli and duct system. Early nursing after delivery and flexible feedings during the first post partum days may significantly decrease breast engorgement in lactating women. This is particularly important because breast engorgement is not only painful, but it is associated with a higher rate of breast infection and lactation failure.

The infant should be nursed every two to four hours (five minutes per breast) in the immediate post partum period, when possible, to promote milk production and prevent breast engorgement from becoming uncomfortable for the mother. This schedule should be continued around the clock. It is a mistake to "allow" the mother who is becoming engorged to sleep through the night if these six to eight hours of non-nursing result in breasts so painfully full of milk that she is then unable to put the infant to breast. Pain, anxiety and tension are all inhibitors of the let-down reflex and may sabotage the mother's nursing experience. If engorgement becomes a problem, it is often advantageous to apply heat (via a shower or warm packs to the breasts) prior to nursing. The use of mild analgesics may be necessary but is avoided when possible. Milk should be expressed from both breasts by manual or pump techniques until the infant can grasp the nipples easily. The baby should then be permitted to nurse until completion, during which time the

mother should massage the breasts thoroughly. Reassurance should be provided to the mother that breast engorgement is normal and temporary, and will not interfere with the success of the breast-feeding experience.

The mother may increase the time the infant nurses to five to 10 minutes per side as her milk production increases, keeping in mind, however, that more frequent and shorter periods at the breast initially are less likely to cause soreness and cracking of the nipples. It is advantageous to air dry the nipples after each nursing session for 15-30 minutes and then apply some type of lanolin-based, non-toxic breast cream, which is rubbed in gently and need not be washed off before the next nursing session. A daily bath or shower is adequate for breast hygiene. The mother should be careful to avoid harsh soaps or drying agents; in fact, simply rinsing with clean, warm water is usually adequate. It is not necessary to cleanse the nipples prior to a feeding as this merely removes protective oils. However, the mother *should* wash her hands carefully before handling her breast.

Positioning the infant to avoid any traction on the nipple is extremely important when placing the infant at the breast. Further, the infant should be able to grasp as much of the areola as possible (milk reservoirs being located behind the nipple). This can be accomplished most easily by first teaching the mother to position herself comfortably. Sitting in bed or on a soft chair with a pillow across her lap is ideal. The environment should be pleasant, quiet and without interruptions or distractions. The mother may then manually express a few drops of milk onto the nipple to encourage the infant to begin to suckle. She may help him grasp the nipple by using her first two fingers to "scissor" or

project it forward. Illustrating the rooting reflex for the mother is also helpful, as it becomes apparent that touching the infant's cheeks may be confusing to the baby. It is best to guide the infant to the breast with gentle pressure on the back of the head.

The key to maximum milk production is adequate emptying of the breasts on a routine basis. To insure total emptying, the mother should be taught to start each feeding with alternate breasts as the infant is likely to suck more vigorously on the side first offered. Since the breast is emptied after seven to eight minutes, it is advantageous to switch the infant at that point to the opposite side and let him finish nursing on the side which still contains a supply of milk. Nursing beyond the eight to 10 minute interval on one side can be emotionally satisfying to the infant, but is often non-nutritive. Breast massage in a circular fashion around the breast while the infant is nursing also will increase milk production by enhancing milk flow. Care should be taken to keep the breasts dry between feedings, as moisture on the nipples may cause excoriation. This can be accomplished using breast pads that absorb leakage of milk (changing the pads as they become saturated) and frequent feeding sessions so that the milk let-down corresponds to the infant's need to nurse. A freshly cleaned, support brassiere should be used each day. Areas of lumps and soreness in the breast that remain after the feeding session need special attention by further massage, milk expression and/or moist heat application to prevent the development of mastitis.

ENGORGEMENT, GALACTO-COELE AND MASTITIS

As already detailed, engorgement is a frequent and normal occurrence during the first days of lac-

tation. Prevention of excessive engorgement (which may limit the ability to nurse) is usually possible with proper instruction and care of the breasts. Early, frequent feedings to stimulate milk production and to promote breast emptying are necessary. The infant should be fed on demand (every two to four hours) during the first days post partum. Adequate massaging of the breasts during nursing is important in maintaining patency of milk ducts throughout the gland.

Should a milk duct become obstructed with inspissated milk over the next several days, it may present as an area of localized tenderness, erythema and swelling. The galactocoele thus formed may be treated effectively by frequent massaging during continued nursing or milk expression. Occasionally, mild analgesics are required. Should superinfection within the galactocoele be suspected, antistaphylococcal antibiotics may be prescribed.

Severe mastitis with generalized infection of the breast parenchyma is a relatively rare complication that normally occurs after the first two to three weeks of lactation. It is the result of bacterial invasion (usually coagulase-positive *Staphylococcus aureus*) into the breast via cracked or fissured nipples. Some degree of engorgement often precedes the actual infection, which is heralded by acute systemic symptoms. High fever and chills, with hardening and tenderness of the entire involved breast, are characteristic. Appropriate management includes expression of milk for culture and sensitivities, and institution of appropriate antibiotic therapy. Continued expression of the milk from the infected breast will reduce discomfort and assist in drainage. Continued nursing from the opposite breast may be possible, although in severe cases, nursing may have to be interrupted or discontinued.

SUPPRESSION OF LACTATION AND WEANING

At present no medications can be recommended for safely preventing normal breast engorgement and milk production in the post partum period of the mother who will not breast-feed. All medications currently available in the United States either have an inadequate success rate and/or possess significant adverse side effects.¹⁰ The recommended approach in the early puerperium is mechanical and supportive. Withdrawal of any suckling stimulus to the breast in conjunction with a well-supporting brassiere and mild analgesics are usually all that are necessary. Occasionally, cold compresses, binders and intermittent partial emptying of the breasts to alleviate exquisite pain are required. Throughout this process the mother must be supported psychologically as well, reassuring her that artificial formula is very suitable and sometimes the preferred method of infant feeding.

Weaning at the completion of the lactation period is accomplished by a gradual reduction in the frequency of feedings over several days to weeks. Should discomfort and engorgement become problematic, measures similar to those utilized in the early post partum period for non-nursing mothers are employed. When to wean an infant is a decision to be made by the mother. In our society, the majority of women wean their infants between three and nine months of age, although prolonged breast-feeding is becoming more common.

NUTRITION DURING LACTATION

A well-balanced diet is to be encouraged; fad diets, strict dieting, excessive non-nutritional food intake or excessive alcohol consumption are to be avoided. Although maternal fluid intake (either excess or restriction) has little,

if any, effect on milk supply,¹¹ fluids should not be limited. The inclusion of three to four cups of milk or equivalent dairy products will ensure adequate protein intake as well. Prenatal vitamins should be continued throughout lactation.

BREAST MILK JAUNDICE

A number of theories have been proposed to explain the protracted hyperbilirubinemia occasionally observed in breast-fed infants. Some of these include a steroid secreted in the milk (pregnane-3 α ,20 β -diol), which inhibits bilirubin conjugation; differences in breast milk digestion and absorption, which affect enterohepatic bilirubin circulation; and increased levels of free fatty acids (because of lipase in breast milk), which may inhibit bilirubin conjugation.¹²

Regardless of the cause, protracted jaundice occurs in approximately 1% of breast-fed infants.¹³ Indirect bilirubin levels do not differ from controls in these babies for the first 96 hours of life, but then continue to rise over the next seven to 14 days before gradually decreasing to normal levels. Absolute levels may reach 25 mg% if unchecked, and must be treated by appropriate means, as for any other cause of unconjugated hyperbilirubinemia in the newborn. The diagnosis is one of exclusion or suspicion. Interruption of breast-feeding for 12-24 hours usually results in a prompt and dramatic fall in the bilirubin level. When nursing is resumed, the bilirubin again may increase slightly but not to excessive levels. During the period when the infant is not suckling, the mother should be instructed in the proper methods of milk expression and reassured that she and her milk are entirely normal.

CONTRACEPTION

It is commonly expostulated that lactation effectively suppresses

ovulation and is, in itself, a safe and effective form of contraception. However, there is a significant risk of ovulation within nine weeks postpartum even while fully breast-feeding an infant, approaching 40% by 18 weeks.¹³ Documented methods of effective contraception are therefore recommended by six to nine weeks after the infant's birth. It is preferable to avoid the use of sex steroids, however, which potentially may affect the infant or the milk (although their use is not considered an absolute contraindication to breast-feeding).

BREAST MILK FOR THE PREMATURE INFANT

The current trend toward breast-feeding is not limited to the mothers of full term, healthy infants. Many mothers desire to express their milk, sometimes for prolonged periods, if their baby is in an intensive care setting. Whether or not breast milk is the optimal form of nutrition for the preterm infant has not been ascertained. Recent evidence suggests that human milk supports normal growth of preterm babies, but that it may not be completely adequate for all low birth weight infants.¹⁴ It is generally agreed that a mother who wishes to continue lactation for a hospitalized infant should be encouraged and supported in her effort. A variety of questions then arise, particularly relating to the preferred method of milk expression, the appropriate method of milk handling and the effects of different means of milk storage. A comprehensive discussion of the guidelines used at the Riley Hospital for Children and the Indiana University Medical Center is available from the authors. Further, a videotape for instruction of the mother who proposes to express milk for her infant has been developed by one of the authors (P.K.L.) and is available for pur-

chase or rental.* In brief, three methods are commonly employed for milk expression: 1) manual; 2) hand pump; 3) electric pump. Either manual or effective hand pump expression is suitable for short term milk collection; however, the electric pump (e.g., Egnell**) is preferred if a period of several days or weeks is anticipated. The milk is collected in sterile plastic containers, and if not fed to the infant immediately, is frozen and stored for up to two weeks. The milk is aliquoted into the approximate volume of the baby's feedings prior to freezing. The risk of contamination by pathogenic organisms is minimal if strict technique is adhered to. Although freezing destroys some host

defense factors in breast milk, a number of bacteriostatic (and possibly other) components remain intact.¹⁵ Feeding the preterm infant breast milk, collected by the above methods and stored by freezing, is a practice endorsed by the American Academy of Pediatrics.¹⁶

SUMMARY

Breast-feeding is the preferred method of feeding for most normal full term infants, and is a reasonable means for feeding the premature baby as well. Although breast-feeding is not appropriate for all mothers and babies, it is the responsibility of the medical community to educate expectant parents of all feeding alternatives so that an informed decision can be made. Should nursing be selected, the medical personnel should counsel the mother so that she is thoroughly familiar with normal lactation and the problems commonly encountered.

*NICER Productions, Indiana University School of Nursing, 1100 W. Michigan St., Indianapolis, Ind. 46223

**Egnell, Inc., 412 Park Avenue, Cary, Ill. 60013

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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JESSIE M. STEVENSON
Indianapolis

IN 1604 KING JAMES I of England issued what was known as a "Counterblaste" on the use of tobacco. There had been a noticeable increase of lip and mouth cancers in men who used the then popular short-stemmed clay pipes. Among the statements in his "Counterblaste" he said: "It is a custome loathsome to the eye, hateful to the nose, harmful to the brain, *dangerous to the lungs*, and in the black stinking fumes thereof, nearest resembles the horrible Stygian smoke of the pit which is bottomless."

In enforcing his "Counterblaste" he put to death all found inhaling fumes of the plant through a tube. Those caught with it under their tongues lost their nostrils and nose. Ex-communication was the penalty for taking it into a church.

However, when King James realized the revenue that could be derived from the plant, he decided in 1613 to take over all powers of

importation of tobacco. Only those who held Letters Patent (which meant they had to give half their profit to the Royal purse) could deal in the commodity. The King became the Royal partner with the merchants Edmund Peschell and Edward White.

Tobacco, which is a herb, was given the generic name *Nicotiana* after Jean Nicot, French ambassador to Portugal. The species of *Nicotiana Tobaccum* is now the chief source of smoking tobacco. It is the only species cultivated in the United States.

While skeptics said it was the cause of almost every disease, its advocates declared it to be a "panacea" for almost every human ailment. It was said to cure fevers, plagues and syphilis. William Byrd, a Virginia planter, advocated its use in the prevention of smallpox. He urged every family to hang bundles of it around their beds and to wear it on their clothes. He believed that it was an antidote against the great plague of smallpox.

Tobacco is native to America. It

was our country's first business venture. George Washington was one of the country's largest planters. It is said in his plea for aid for the Army he wrote: "I say, if you can't send money, send tobacco."

The Indians considered tobacco as a gift from the Great Spirit given for their pleasure and enjoyment. They believed he took of it for the same reasons. The pipe was considered sacred and was an important factor in waging war and in establishing peace.

After tobacco became legalized in England, school children (minus breakfast) carried a pipe of tobacco to school, and along with the School Master, smoked at recess time. It was one of the duties of the School Master to teach the children the correct way to hold their pipes.

Of the three methods employed in the use of tobacco, namely, chewing, snuffing, and smoking, the latter has been discovered to be the most damaging to health.

It is interesting to note how medical researchers concluded that cigarette smoking is such a health

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hazard. In performing autopsies upon those who had died of lung cancer who had been heavy smokers, they noted a correlation between the condition of their lungs and the lungs of those who had worked in the mines and had died of the same cause. The researchers decided to investigate the substances emitting from cigarette smoke, which they felt might have affected the lungs of the victims who had died of lung cancer.

In the case of the miners, the substances found which contributed to their diseased lungs were radium, uranium, arsenic, nickel and cobalt. The substances found in cigarette smoke were no less potent—nicotine, tar and carbon monoxide being the most dangerous. The inherent danger of these substances has been well verified by medical technology:

- Nicotine is an alkaloid poison, and is considered to be the additive element in tobacco. It constricts the blood vessels. It is capable of stimulating the heart rate as much as 20 beats a minute. This situation may continue for 20 minutes after smoking. For heavy smokers this may mean as many as 10,000 extra beats a day. Thus the extra burden placed upon the heart accounts for the fact that coronary heart disease is the most important single cause of mortality among cigarette smokers.

- Tar condensate is made up of hundreds of chemicals that contain most of the known cancer causing agents in cigarette smoke. Tar damages the very delicate lung tissues. Even with the reduction of tar in filter cigarettes the lung cancer risk is four times higher than that of non-smokers.

- Carbon monoxide displaces the oxygen in the red blood cells. The oxygen carrying blood capacity can be reduced as much as 10%. It also causes circulatory problems because it makes the arteries permea-

ble. Carbon monoxide stays in the blood stream as long as six hours after a person quits smoking.

Smoking has been connected to causes of cancer of the pharynx, esophagus, pancreas and bladder. It is also the principle cause of chronic bronchitis and emphysema.

Pipe smoking seems to be a primary cause of cancer of the lip. Cancer of the mouth, throat, larynx and stomach is attributable to cigar and pipe smoking.

There are higher levels of tar and nicotine in most brands of little cigars than is to be found in cigarettes. Moreover, non-smokers say, smoke from pipes and cigars is more annoying than cigarette smoke.

Furthermore, second-hand smoke can have harmful effects on non-smokers. It can make the heart beat faster, step up blood pressure and raise the level of carbon monoxide in the blood of the non-smoker.

A task force sponsored by the American Cancer Society concluded that teenagers are 50% more likely to smoke if the adults with whom they are associated smoke.

An American Lung Association pamphlet says only two-thirds of young women who smoke realize that smoking can harm an unborn baby. It can cause still births, spontaneous abortion and premature deliveries.

It has been estimated that more than 10% of all hospital and medical expenses in the United States are tobacco related.

A study conducted by the State Mutual Life Assurance Company of America at Worcester, Massachusetts, based on its experience for the past 15 years, states: "If non-smokers are considered the standard group then over a broad range of adult ages, 20-65, the overall mortality rates among smokers runs 2-4 times those of 'standard' risk."

The Health Letter of Oct. 26, 1979, says cancer of the lung is the most common cause of cancer deaths in the United States (approximately 60,000 deaths a year in men and over 15,000 deaths in women), and that 80% occur in cigarette smokers. We can visualize this to be true when we realize that the inhaling smoker retains 70% of the particles he breathes.

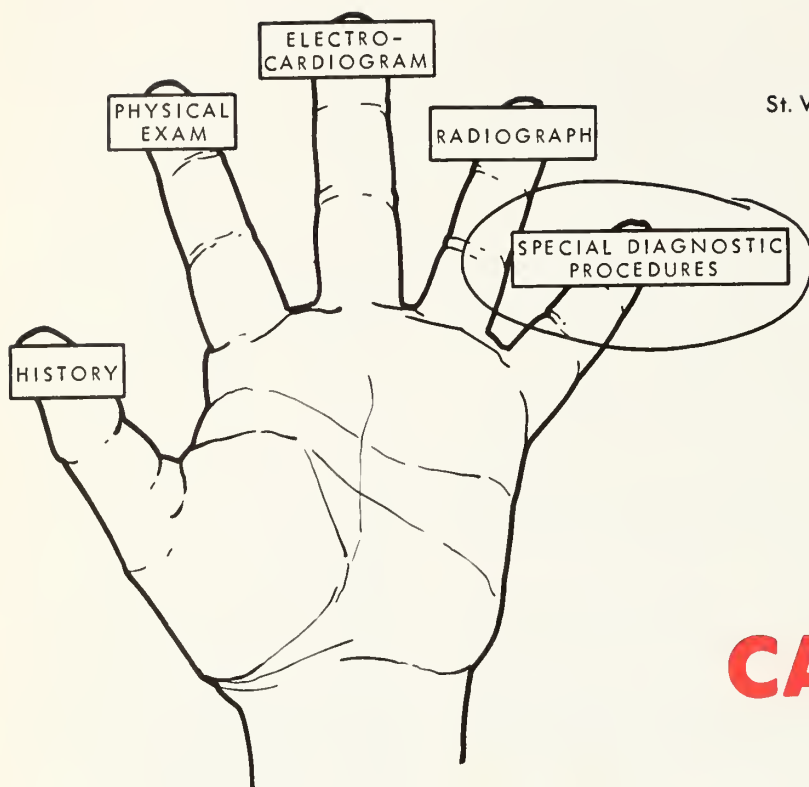
A Medical and Health Annual in 1977 states: "The longer and the more one smokes, the deadlier smoking becomes. Death rates from all causes are from 40 to 120% higher for smokers than non-smokers, depending on the amount smoked daily."

No major medical or health agency questions the fact of the life-destroying potential of tobacco in its varied forms of usage, especially in cigarette smoking. Thousands of careful studies have attested to the absolute truth of the irreparable damage it does to the human body, in loss of life, disability and financial pressure in terms of medical costs.

A bright side to the problem is emerging at the present time and a report made by the American Public Health Association in 1959 will probably be proven false. The report predicted: "Lung cancer will claim the lives of more than 1 million present school children in this country before they reach the age of 70 years if present trends continue." However, the American Cancer Society recently reported that 30 million adult Americans have kicked the habit.

The American Lung Association fittingly declares, "The only safe cigarette is no cigarette."

Much publicity has been given in recent years extolling tobacco as a social enrichment to life. However, King James I in 1604 recognized it as a health hazard when he said, among other things, "*it is dangerous to the lungs.*"



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THE FIVE FINGERS OF CARDIOLOGY

The Five-Finger Approach to Cardiac Diagnosis was conceived by W. Proctor Harvey, M.D., of Georgetown University, and further developed by J. Willis Hurst, M.D., of Emory University into its present form: The integration of all five approaches is diagrammed into a "fist" of cardiac-diagnosis.

Periodically, THE JOURNAL will present a "finger of cardiology" as a self-assessment, emphasizing current and innovative diagnostic and therapeutic principles.

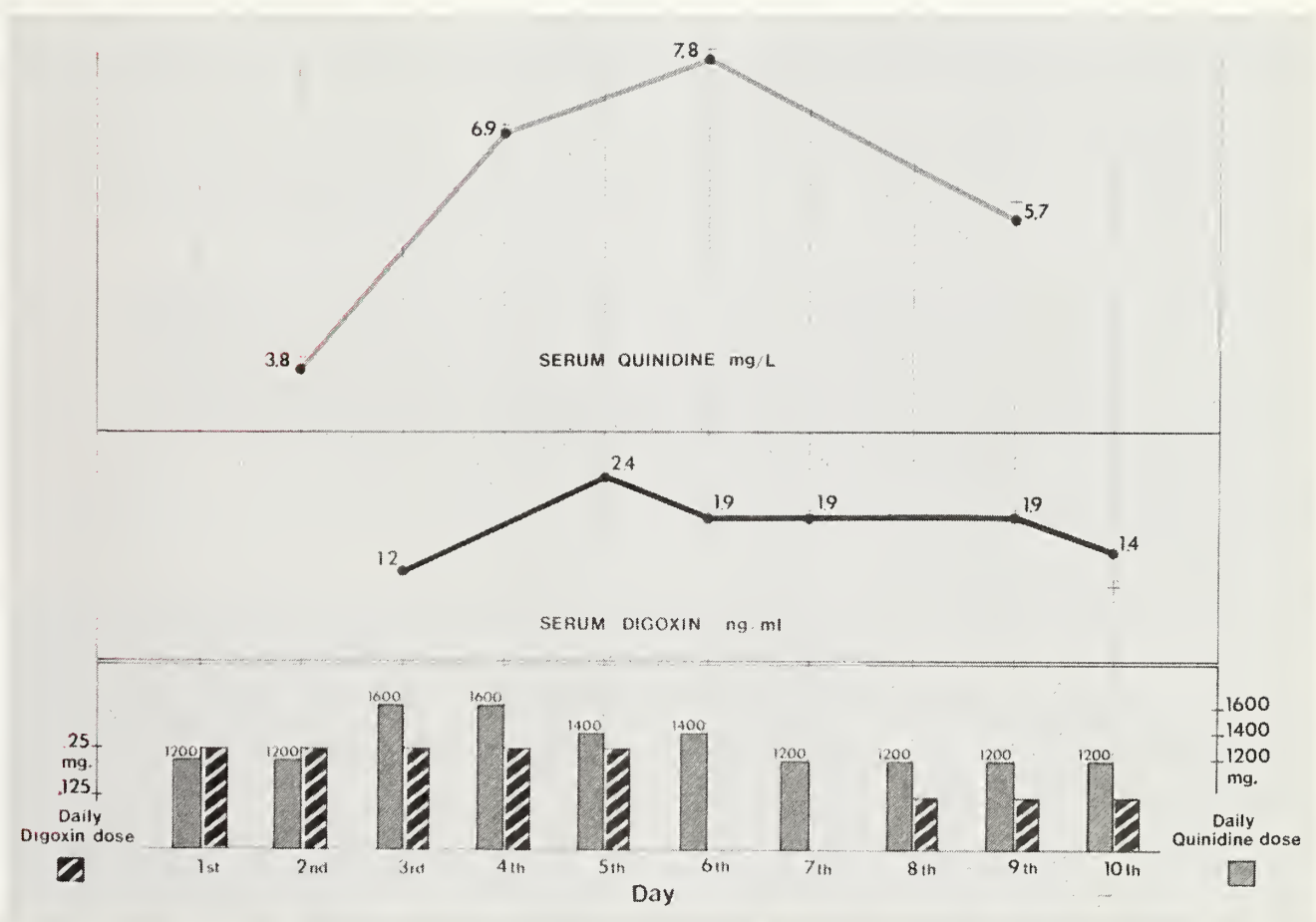
A 63-year-old gentleman is admitted to the hospital for therapy of recurrent ventricular tachycardia, associated with coronary artery disease and resultant severe left ventricular dysfunction.

The patient has chronically received digoxin, 0.25 mg daily, in addition to diuretics. Quinidine, in a dosage of 1,200 mg per day, is initiated upon admission to the hospital. The subsequent daily dosages, and serum blood levels of quinidine and digoxin are recorded in the illustration.

QUESTIONS

- Why does the serum digoxin level double between the second and fifth hospital day, when the dosage of digoxin has not been altered? Incidentally, renal function was normal, and did not change during the hospitalization.
- Even though the digoxin was discontinued on the fifth hospital day, why did the serum digoxin levels remain stationary until the ninth hospital day?
- Why was the final digoxin level approximately equal to the initial blood level, when the dosage of digoxin was cut in half?

A Self-Assessment



ANSWERS

In the past year, an exceptionally important interaction between quinidine and digoxin has been discovered. Specifically, the administration of quinidine to a patient on digoxin results in a substantial increase in the serum digoxin level, to approximately twice its initial

value. Digitalis intoxication is common as a result of this interaction.

The specific mechanism explaining the interaction is unclear. Perhaps quinidine results in the release of digoxin from binding sites, such as in the skeletal muscle. Alternately, quinidine may alter the renal excretion of digoxin. Whatever

the mechanism, the clinical lesson is certain: To avoid digitalis intoxication, serum digoxin levels must be carefully followed, or the serum digoxin dosage must be reduced to about half of its previous maintenance levels when therapeutic concentrations of quinidine are achieved.

Idiopathic Sudden Hearing Loss

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Any individual of any age can experience a sudden loss of hearing. This loss is typically neural in type, unilateral, of moderate to severe degree, often in a person of good general health, accompanied by tinnitus, and frequently associated with varying degrees of dysequilibrium, nausea and vomiting. An individual with a unilateral sudden hearing loss has increased difficulty understanding in a noisy or crowded room, loses the ability to determine the direction of sound and can no longer enjoy stereo music.

THERE ARE MANY CAUSES of a sudden neurosensory hearing loss. In approximately 15% of cases an etiology can be uncovered that at times may result in a satisfactory outcome with proper treatment.

Viruses. Mumps, rubeola (red measles), rubella (German measles), varicella (chicken pox), herpes zoster (shingles), smallpox, adenoviruses, cytomegalic viruses, Coxsackie virus and the virus of the common cold have been incriminated as a cause of sudden hearing loss. The clinical diagnosis of viral infections (except mumps parotitis and herpes zoster) has been unreliable. Many losses probably are due to sub-clinical viral infection. There have been, unfortunately, no studies clearly correlating the type of virus involved and pathophysiology of the loss. Treatment has been uniformly unsuccessful for this problem.

Bacteria. Acute and chronic infections of the middle ear can reach the inner ear via the blood, meninges, or by otogenic extension. Suppurative labyrinthitis is

characterized by complete deafness and permanent destruction of the sensory elements of the labyrinth. Serous labyrinthitis is primarily a nonpurulent labyrinthitis in which bacterial or viral toxins can invade the inner ear and cause neurosensory hearing depression, vertigo and nystagmus, which are reversible if promptly treated. Circumscribed labyrinthitis causes a hearing loss as a result of bony erosion of the labyrinth usually by cholesteatoma with focal inner ear inflammatory reaction. The sensorineural loss indicates perilymph contamination by the toxic or infectious process. Prompt medical and surgical intervention can eradicate the pathologic process.

Drugs. Alcohol, arsenic, lead, zinc, quinine, aspirin, streptomycin, dihydrostreptomycin, kanamycin, viomycin, neomycin, ethacrynic acid, colistin and furosemide can cause sudden hearing loss. Appropriate monitoring and withdrawal of these drugs can prevent or reverse some drug-induced hearing loss.

Lues. A neurosensory hearing loss with an associated severe decrease in speech discrimination can be due to syphilis of any stage as well as late congenital syphilis. The fluorescent treponemal antibody absorption test (FTA-ABS) is highly diagnostic. Long-term treatment with steroids and penicillin can improve and arrest losses of this origin.

Noise. Acoustic trauma can result in a sudden hearing loss. There is no satisfactory treatment other than avoidance of future exposure.

Congenital. The Mondini type of congenital inner ear deformity can be detected by polytomes of the temporal bone. In this congenital abnormality, there is an absence of the osseous spiral lamina between the apical and middle turns of the cochlea. The membranes are subject to rupture with increased perilymph pressure via the cochlear aqueduct when the individual strains and increases cerebrospinal fluid pressure. Hair cell damage occurs with a mixing of perilymph and

From Otologic Associates, Inc., The Wright Institute of Otolaryngology, 5506 E. 16th St., Suite 22, Indianapolis, Ind. 46218.

endolymph. In cases where all hearing was lost in one ear and is decreasing rapidly in the other ear, surgery of the endolymphatic sac has arrested further loss in the remaining hearing ear.

Meniere's Disease. Five per cent of patients with a sudden hearing loss will develop Meniere's disease. Appropriate medical and/or surgical measures may recover some of the loss.

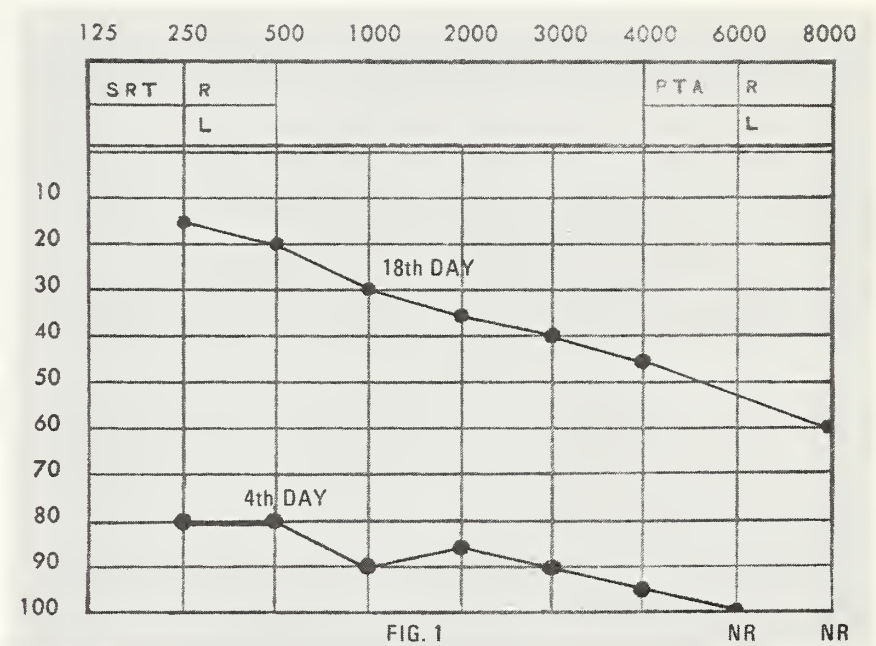
Post-stapedectomy fistula. Patients who have had stapes surgery for otosclerosis may suddenly develop unsteadiness and a loss of speech discrimination. A perilymph fluid leak may occur in the area of the oval window. Prompt surgical closure of this leak often will correct this problem.

Miscellaneous. Sudden hearing loss also may occur after general anesthesia, in autoimmune states, with multiple sclerosis, in patients on renal dialysis, and in association with metastatic cancer.

**IDIOPATHIC
SUDDEN HEARING LOSS**

Idiopathic sudden hearing loss due to neurosensory depression is that type of loss for which no definite etiology can be found. Its incidence has been reported to be an average of 10.7/100,000 population.¹ This loss occurs instantaneously or within a 12-hour period. The patient complains of a sensation of blockage, sound intolerance, distortion, echoing or a combination of these symptoms. There may be varying degrees of dysequilibrium with nausea and vomiting.

The evaluation of the patient consists of a careful history with questions about barotrauma, pressure changes, physical exertion, previous ear surgery, recent infection or upper respiratory problems with sneezing and coughing, drug



The audiogram of a 22-year-old woman begun on daily intravenous radiopaque media on the fourth day after a sudden unilateral nerve loss. Treatment lasted 10 days. Hearing improved dramatically.

usage, alcohol intake, smoking, acoustic trauma, cardiovascular disease, tinnitus and vertigo.

A complete neurotologic examination is performed. Polytones of the temporal bone, an electronystagmogram (ENG), a complete audiometric profile, and a brain-stem-evoked-response (BSER) study are obtained. Laboratory studies may consist of a metabolic profile (5-hour glucose tolerance test, thyroid tests, lipid profile), sedimentation rate and an FTA-ABS.

In idiopathic sudden hearing loss, all tests except the audiogram usually are normal. The severity of the loss is based on the average of the three speech frequencies of 500, 1,000 and 2,000 Hz. A mild loss is defined as 34 decibels or less; a moderate loss is 35-54 decibels; a severe loss is 55-74 decibels; a profound loss is one greater than 75 decibels.

Polytones can detect congenital abnormalities (Mondini type), in-

fectious causes, fractures, ossicular dislocations, and tumors.² The ENG reflects central or peripheral (labyrinthine) vestibular involvement. The brain-stem-evoked-response study (BSER) is helpful in diagnosing hearing loss in young children,³ that loss due to small acoustic neuromas,⁴ and brain stem lesions (intra-axial-pon-tine-masses).⁵

TREATMENT

The treatment of sudden neurosensory hearing loss of unknown etiology has been equivocal. Vasodilators, anticoagulants, diuretics, dorsal sympathectomy, repeated smallpox vaccination, intravenous Xylocaine, and anti-inflammatory agents (steroids) have been used. There actually have been 108 different treatment modalities reported in one study of the subject. In most series, the recovery rate was not much different than that occurring with no treatment at all (40-50%)!

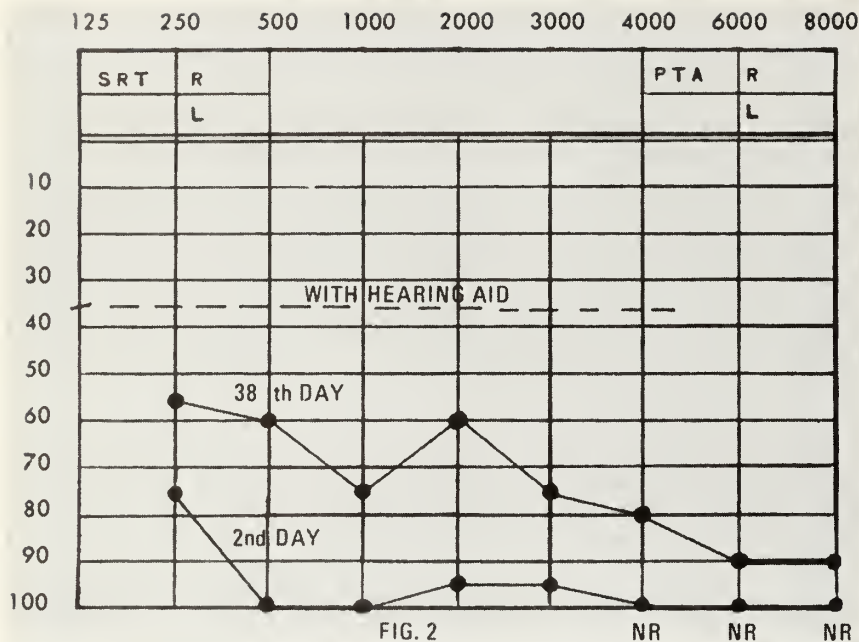


FIG. 2
An 82-year-old man with a sudden loss of hearing in his only hearing ear. After daily intravenous radiopaque contrast media, hearing improved sufficiently to allow communication with the help of a hearing aid.

Simmons *et al*⁶ have shown that certain important factors regarding the outcome of sudden hearing loss are: 1) the contour of the initial audiogram; 2) time of diagnosis; 3) speech discrimination scores; 4) the erythrocyte sedimentation rate (E.S.R.); and 5) vertigo.

Audiogram. An upward-sloping audiogram has an 80% chance of good or complete recovery. If hearing is poor at the 8kHz. frequency, no matter what loss is at other frequencies, the prognosis is poor (29%).

Time of diagnosis. For most people, recovery is strictly a function of time. Those patients whose hearing recovers early (within 7 days) usually never get to the doctor.

Speech discrimination. Patients with a moderate to severe hearing loss with good speech discrimination usually do well.

E.S.R. Patients with an E.S.R. over 30 usually have steep, downward-sloping audiograms and have a poor prognosis.

Vertigo. Patients with significant vestibular symptoms in association with the hearing loss have a poor prognosis. A hypoactive caloric response predicts a poor prognosis for high-frequency hearing recovery; a normal caloric may correspond with a better prognosis.

Fifty per cent of patients will recover within a week. The remaining patients have variable recovery rates.

Recently, patients with sudden hearing loss have shown improvement with the use of intravenous radiopaque contrast media.⁷⁻¹⁰ Injecting a sodium salt contrast medium may restore normal function to the stria vascularis within the scala media. Presently, we are treating patients with sudden hearing

loss with radiopaque contrast media, but data thus far are not conclusive and await further evaluation (Figures 1 and 2). The use of hyperbaric oxygen has been reported beneficial in the treatment of hearing loss due to Meniere's disease.⁹ Prospective treatment of sudden hearing loss with this modality warrants consideration.

DOUBLE MEMBRANE BREAKS

A word should be said for an entity previously categorized as idiopathic sudden hearing loss but now shown conclusively to be otherwise.^{11,12} Physical stress, such as diving, straining, or trauma, can result in a break in the oval and/or round window membranes in association with intracochlear membrane rupture. Sudden hearing loss is associated with spatial disorientation in over 90% of cases.

It has been postulated that a break in one fluid compartment, i.e., perilymph, causes a break in a second compartment, i.e., endolymph. A mixing of the fluid causes hearing loss by disturbing inner ear ionic balance, changing inner ear compliance, or by changing the pathway of vibrating energy in the inner ear. The intra-cochlea membrane break may heal spontaneously with a recovery of most of the hearing loss due to it. But if the break at the oval or round windows persists, hearing loss with or without dysequilibrium may persist unless corrected surgically.

Surgical intervention is guided by the shape of the audiogram and the degree of spacial orientation. Upward slopes show a spontaneous recovery rate of over 90%; downward slopes have a less than 30% recovery rate. Treatment consists of rest and frequent audiograms. A progression of hearing loss or increase in vestibular symptoms is an indication for immediate surgery.

SUMMARY

In case of sudden neurosensory hearing loss, a potential correctible etiology can be uncovered in 15% of cases. Thus, all cases of sudden hearing loss warrant immediate evaluation.

A favorable prognosis occurs when the sudden hearing loss is associated with a flat or upward-sloping audiogram, satisfactory speech discrimination scores, and a short time between onset and diagnosis.

An unfavorable prognosis occurs when the sudden hearing loss is associated with a downward-sloping audiogram, vertigo, an elevated sedimentation rate, delayed diagnosis, and, to a slight degree, the elderly patient.

The use of intravenous radio-

paque contrast media is presently being evaluated in the treatment of sudden hearing loss. The use of hyperbaric oxygen therapy also warrants future considerations.

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CLINICAL NOTES

Topical Corticosteroids

Dermatologists are often asked, "Which is the best topical corticosteroid preparation?" So many complications occur from the stronger topical agents that one should use the least potent medication that will do the job. However, agents of like anti-inflammatory activity can differ markedly in their potential to cause particular "side effects."¹ The vehicle used also can have a dramatic effect on steroid penetration and activity.^{2,3} Therefore, the clinician must be eclectic in his use of these agents, selecting an adequate but not excessively potent preparation appropriate for that situation. Patients with multiple problems may on occasion require separate topical steroid medications.

The anti-inflammatory activity of topical steroids has been ranked on scales of one to six⁴ and one to four⁵ based on vasoconstrictor properties. While this measurement may not always parallel anti-inflammatory activity, there is little doubt that hydrocortisone (alcohol) is a relatively weak anti-inflammatory agent, whereas fluocinonide (Lidex®) is more potent.

The specious belief has arisen that only fluorinated corticosteroids cause complications. However, the valerate or butyrate esters of hydrocortisone are quite potent and will rival many of the fluorinated corticosteroids. Cotterill⁶ reported seven patients who developed perioral dermatitis following the application of hydrocortisone butyrate and others have even reported the condition in patients who had used hydrocortisone.^{7,8}

The incidence of complications will probably parallel steroid potency⁴ but the tendency for particular side effects can be minimized by proper choice of therapeutic agents. Triamcinolone is more likely to produce atrophy¹ or striae atrophicans, especially in the inguinal area.⁹ Betamethasone valerate preparations, on the other hand, are followed by little more atrophy than hydrocortisone¹ but may lead to perioral dermatitis if used on the face.¹⁰ Clobetasol dipropionate cream, which is not available in this country, can produce marked atrophy, and as little as 15 grams can lead to adrenal suppression.¹¹ Of the medications available here, one can probably use 30 grams per week in an adult and 10 grams per week in a small child without undue risk of adrenal suppression.¹²

Anti-inflammatory activity also is influenced by vehicle compatibility² as well as ingredients

that break the "barrier" in the stratum corneum. Desonide is an extremely effective topical steroid, but it is reduced in potency by the vehicle. Similarly Kenalog® cream is more active than Aristocort® cream, although they contain the same corticosteroid.¹⁰ Ointments, in general, are more potent than creams containing the same agent, but there are exceptions. The effectiveness of hydrocortisone is enhanced by the addition of 10% urea.¹³

One cause of vehicle intolerance is sensitivity to one of its components. Perhaps the leading example of this is allergy to ethylenediamine, a stabilizer in Mycolog® cream, which was discussed in a previous Clinical Notes article.¹⁴ Vehicle sensitivity also can be due to preservatives, propylene glycol, lanolin products, emulsifiers and even perfume.

Reports of paraben sensitivity led many manufacturers to remove this preservative from their products. In my practice, I find other preservatives are as likely to induce sensitivity. Most of my paraben-sensitive patients are those sensitive to Mycolog® cream. Here, sensitivity to ethylenediamine may have an adjuvant effect.¹⁴

Patch testing to topical steroid preparations most often is negative because the steroid component interferes with the response. To prove such allergy, one must test the components in proper concentration. In my experience, sensitivity is most common with Mycolog® cream and least probable with Aristocort® ointment, which comprises only triamcinolone acetonide and petrolatum. Allergies to corticosteroids and petrolatum have been reported but are extremely rare.

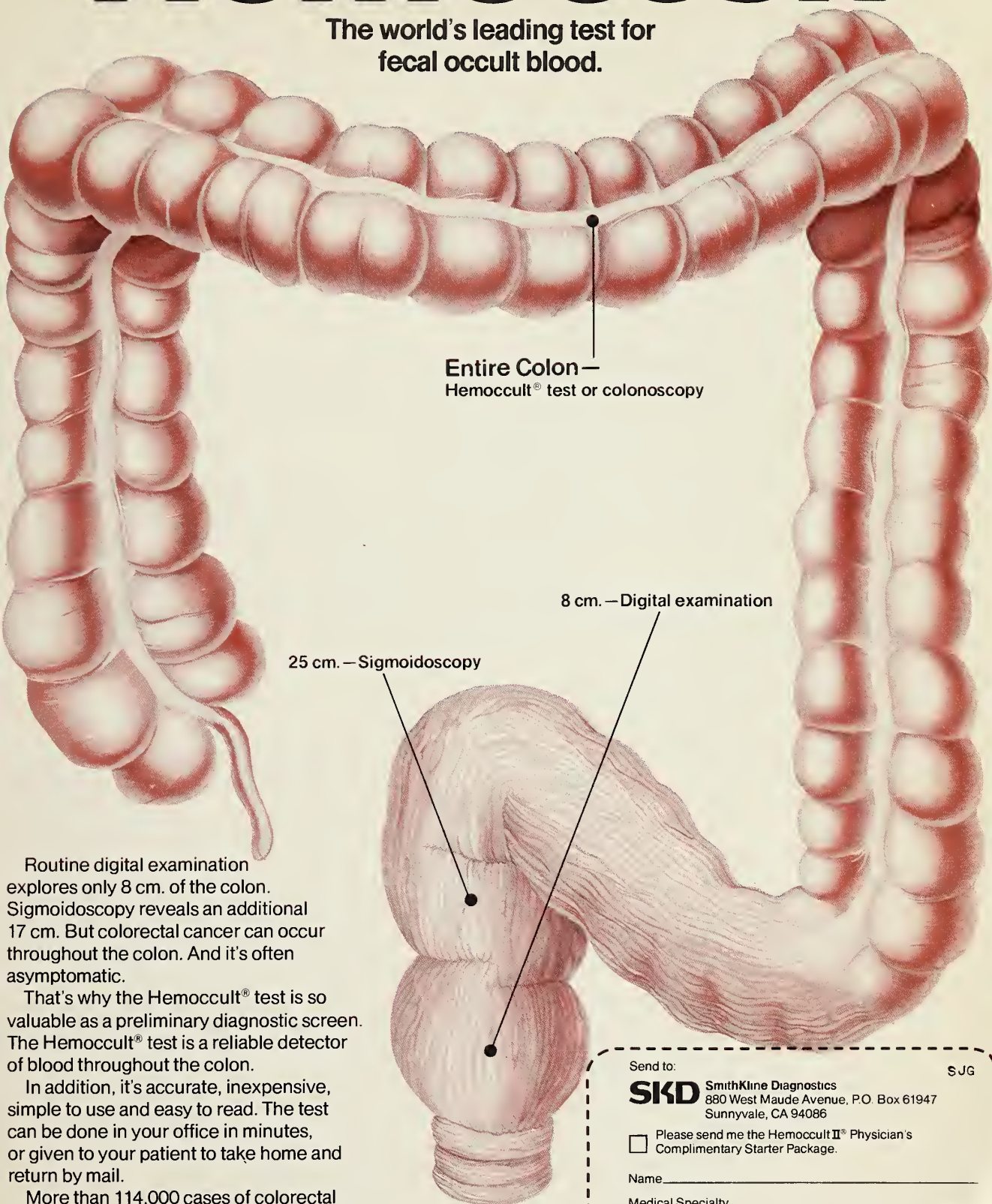
What about the differences in the patient and area to be treated? Absorption is likely to be greater in infants or areas, e.g., the face, scrotum, and intertriginous areas where it is generally prudent to use less potent corticosteroids. In areas prone to develop atrophy, one should avoid triamcinolone acetonide and consider hydrocortisone or perhaps betamethasone or hydrocortisone valerate, should more potency be required. Weaker agents can then be substituted after control is achieved.

The choice of vehicle also is important. The gel form of some corticosteroids is useful in some patients with psoriasis, and Topsyn® has been rumored to be beneficial in such diseases as lichen planus, granuloma annulare and cutaneous sar-

CONTINUED ON PAGE 393

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FOR COLOSTOMY PATIENTS To ensure formed stools, give one to two rounded teaspoonfuls of Perdiem™ in the evening with warm liquid.

DURING PREGNANCY Give one to two rounded teaspoonfuls each evening.

FOR CLINICAL REGULATION For patients confined to bed, for those of inactive habits, and in the presence of cardiovascular disease where straining must be avoided, one rounded teaspoonful of Perdiem™ taken once or twice daily will provide regular bowel habits. Take with a full glass of water or beverage.

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CLINICAL NOTES

CONTINUED FROM PAGE 388

coid where systemic steroids or intradermal steroid therapy formerly might have been used. Lotions are valuable when treating the scalp. Ointments usually are more potent than creams and are useful where there is hyperkeratosis and absorption is minimal. Creams are popular because they can be rubbed in and they do not leave a greasy film. After all, nothing is effective if the patient will not use it, and creams are acceptable to some who might refuse to use an ointment.

Complications arising from topical corticosteroid therapy include contact sensitivity, localized atrophy, purpura, steroid rosacea, telangiectasia, acne, rosacea, perioral dermatitis, adrenal suppression, striae atrophicans, and the masking of underlying dermatoses. Less potent corticosteroids give rise to fewer problems but they are not immune to complications. Hydrocortisone is now a non-prescription drug, so one should look for possible problems from even this relatively weak agent.

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BOOK REVIEWS

Aborting America

Bernard N. Nathanson, M.D., with Richard N. Ostling. Copyright 1979, Doubleday & Company, Inc., New York, N.Y. 320 pages, including bibliography and index. \$10.

This book is like no other I have ever read, except that there is just a little bit of Rabelais in it—that is, a dissection of one facet of society. Here is a man who followed in his father's footsteps as an obstetrician-gynecologist, but broke with him over a matter of religion. He entered practice in 1957, having earned his M.D. at McGill. He spent a year at Michael Reese Hospital, with residency at Woman's Hospital, N.Y.

He became progressively more dissatisfied with the problems and status of abortion and gives an excellent and frank account of the anatomy and physiology of a hospital consultation for therapeutic abortion: "As I assumed larger responsibility for the care of clinic patients, I was confronted for the first time with what seemed to me to be the tragic wastefulness, infuriating injustice, and medical hypocrisy surrounding the abortion problem." He then describes vividly the results of D and C for incomplete induced criminal abortion according to whether the woman was lucky or not lucky. He later (1967) became part of a group intent on legalizing abortion on demand, and eventually a leader in the National Association for Repeal of Abortion Laws (1969-1975).

This led to his becoming director of the Center for Reproductive and Sexual Health (1971-72), which then was the largest abortion clinic in the world. Later, the NARAL became the National Abortion Rights Action League.

Strangely enough, not long before the Blackmun decision in 1973 (*Roe v. Wade*) he began to notice an uneasiness in his feelings toward abortion on demand. In fact, in an article entitled "Deeper into Abortion" (NEW ENGLAND JOURNAL OF MEDICINE, Nov. 28, 1974), he stated: "Some time ago . . . I resigned as director of the Center for Reproductive and Sexual Health. The Center had performed 60,000 abortions with no maternal deaths—an outstanding record of which we are proud. However, I am deeply troubled by my own increasing certainty that I had in fact presided over 60,000 deaths. . . . I plead for an honest, clear-eyed consideration of the abortion dilemma—an end to blind polarity." The paper quoted is reprinted about half-way through the book, and the remainder of this work is devoted to a detailed consideration of what is involved in a "clear-eyed consideration" of the subject.

A sample of his insight (and originality) in the analysis is his recognition of the fact that a new term is needed in order even to begin to discuss (without rancor) "the entity that lies at the heart of the debate": baby, person, human being, human life, fetus, embryo, conceptus, etc. He proposes to call "this mysteri-

ous intrauterine occupant, at whatever stage, *alpha*. This is "the only way to maintain a neutral and an unemotional approach. . . ."

He considers the religious denominations and their various attitudes toward abortion and concludes: "I think that abortion policy ought not be beholden to a sectarian creed, but that obviously the law can and does encompass moral convictions shared by a variety of religious interests. In the case of abortion, however, we can and must decide on the biological evidence and on fundamental humanitarian grounds without resorting to Scripture, revelations, creeds, hierarchical decrees, or belief in God. Even if God does not exist, the fetus does."

Even the term abortion is "fuzzy." On O.R. schedules, "the pre-Blackmun term that was written down was *therapeutic abortion*; after Blackmun it became *elective abortion*. Now it is *termination of pregnancy*, the ultimate euphemism, almost Huxleyan in its finesse. To the gynecology residents it remains *scraping it out*."

In pursuit of the solution to the problem, he has an occasional (sometimes acerbic) aside, such as: "It is worth pondering that the abortion ethic contrasts with the new ecological sensitivity. The same society (and some of the same individuals) that lavishes great care over the peregrine falcon or the Furbish lousewort is willing to accept mass alpha-cide with equanimity."

Chapter 19, "The Specious Arguments in Favor of Abortion," should be read by all, and it leads into Chapter 20, "Signals from Inner Space," where the marvels and discoveries of modern technology relative to alpha are presented. "If we can break the code, alpha will have a million messages for us." This chapter points out that while "the Supreme Court, altering historic protections, defines the concept of *person* in order to permit the elimination of alpha, we in science are continually widening the concept of life."

In Chapter 21, "If Wombs Had Windows," on the matter of "viability" he shows the unconformities involved when the strata of Blackmun were overlaid by subsequent court decisions (*Colautti v. Franklin*, *Doe v. Bolton*, etc.). "Blackmun's incursion into medicine was ill-informed in that he seemed unaware that all discussion of viability and survival rates must be based upon weight in grams, not weeks." Nathanson maintains that the concept of "viability" is "impossibly vague and unstable."

Another quote: ". . . we are waging this war against alphas at a time when the alternatives are much more promising than in earlier times when civilization rejected abortion. . . . Alpha, an innocent party, has no alternatives. We are not pro-choice when alpha's presumed choice is at stake." He then taken up the five categories of cases cited to justify a "just war" in the womb: the trivial, the social, the eugenic, unjust preg-

CONTINUED ON PAGE 396

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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani.

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Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants. Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories — Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at

bedtime for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream — Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0047-0089-12) and boxes of 24 (N 0047-0089-24) in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream — one-ounce tube (N 0047-0090-01) with plastic applicator.

Store between 59°-86° F (15°-30° C).

Full information is available on request.

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Morris Plains, NJ 07950 USA

2/80

BOOK REVIEWS

Aborting America

CONTINUED FROM PAGE 394

nancy, and the medical, and this short chapter on "Just War in the Womb?" is perhaps the most poignant of all.

Chapter 26, "Ought There Be a Law?" is short but rigorous, and the "Epilogue" is a fitting conclusion, with a quotation of Dr. Seuss' "Happy Birthday to You!" occupying the entire last page most effectively. Just before that, his parting wave is: "Only the recognition that the alpha is but one of us, and that we must welcome it back into the community of mankind, will serve us as a reliable guide for our implacable future."

Everyone with sensibility above the reptile stage should read this book—especially physicians and women. It will at least arouse their thinking and may be just the clarification they have been seeking.

A. W. CAVINS, M.D.
Terre Haute
Gynecology

Explorers of the Body

Steven Lehrer, M.D. Copyright 1979, Doubleday & Co., Inc., New York, N.Y. 463 pages, \$12.95.

This publication is an extremely well documented and complete history of medicine. It reflects the very thorough, basic considerations of life and the body in its functions. The author has, with great effort, explored the entire subject dating back to the earliest records of primitive medicine and followed through to the most recent advances. He has produced a comprehensive and interesting summary of the science of medicine.

Dr. Lehrer says, "The art of healing is an old one, and it antedates even the evolution of modern man more than 100,000 years ago and was also practiced by other primates."

Activity in the craft of medical procedures has been noted even in prehistorical days. The primitive man, by his own exposure to the sun, severe and changeable weather conditions, self protection and the need of survival in the rugged environment, exhibited a crude form of treatment of abnormal states which followed the medical maneuvers as practiced by primates on each other.

The science of healing is newer than the art. Present-day procedures, techniques and advancements in the practice of medicine are the results of many, many individuals who because of curiosity, desires, research and experimentations have produced the high level of perfection in medicine as we know it today.

Dr. Lehrer has traced the history back to the Greeks in the era between 500 B.C. and 500 A.D. as described in the writings of Hippocrates, Plato and Aristotle through the decades into the time of well known sci-

tists such as Pasteur, Jenner, Mendel, Currie, Salk, Harvey and many others, and the enormous influence it has produced in the exploration of the body.

The book is most informative relative to basic considerations of blood studies, circulation, respiratory functions, the biological legacy, anesthesia, surgery, the discovery of the infectious processes, the survey of malignancies, radiation and chemotherapy (for a hope in the control of such tumors). A better understanding and explanation of the hormones, the discovery of such preparations as antibiotics, insulin and the eradication of such severe illnesses as polio, smallpox and diphtheria have all been the result of the continuous effort of doctors, researchers, physiologists and explorers who were interested in the body.

This publication is extremely well written, very unusual, very inclusive, and very educational. I recommend it as a "must" for everyone interested in medicine.

IRVIN W. WILKENS, M.D.
Indianapolis
Internal Medicine

I Medici Scrittori dal XV al XX secolo

Arnoldo Cherubini, M.D. Copyright 1977. Editalia, Edizioni d' Italia, via di Pallacorda 7, Roma.

This is not only a beautiful book in the strictest sense of the word, but it is also a book beautifully written (in Italian) and assembled.

Arnoldo Cherubini has done an incredible amount of work researching and documenting the influences and contributions of the medical profession to the world literature.

The author covers a broad territory, from the renaissance period in Italy with figures like Bernard Ilummo up to a brief but exhaustive look into the future and the new generation in the 20th Century. Obviously, most of the material originated in Europe but Cherubini also makes frequent incursions in the Americas.

He has extensively researched every aspect of the literature from poetry to critic. One discovers throughout the book the immense contributions brought by these "poet M.D.s," not only to the art of their own country but also to the world literature in general. To crown his work, the book is beautifully dotted by extracts from various authors and by a multitude of magnificent illustrations showing the state of medicine during our history.

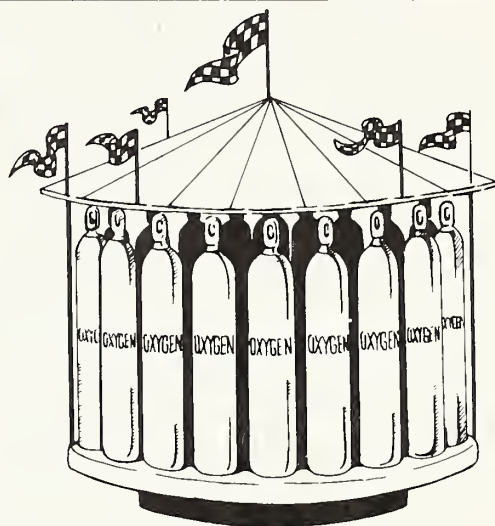
Even if one is not familiar enough to read Cherubini's book in Italian, it is worth one's effort to study the illustrations, which speak for themselves. A must for anyone interested in medicine and literature.

WILLIE MANFREY
Licensing Manager
Dow Pharmaceuticals



Attention Physicians:

Do You Have Patients On The Oxygen Cylinder Merry-Go-Round?



Oxygen Tank Deliveries
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If you have patients using oxygen, call now for information on how they can get rid of those unsightly and inconvenient tanks. New oxygen concentrators make oxygen continuously out of the air in the patient's room, eliminates deliveries, and ends worry about ever running out of oxygen again. This marvelous new unit can even save money for patients who use more than 3 each H tanks per week. For more information on safe, continuous oxygen supply in the home call:

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Phone 1-219-432-3321



Physician Community Service Award

The Indiana State Medical Association is
now actively seeking nominations for the 1980 Physician
Community Service Award.

With this award, we wish to recognize and honor individual
physicians who have contributed outstanding
and meritorious service
to their local communities and to the state in
voluntary service.

You can help.

If you know of a fellow physician whose community
service you believe should be recognized, contact your
county medical society.

Nominations must be submitted to ISMA by the county
medical society of which the nominee is a member.

Won't you do your part in honoring
deserving fellow physicians?

Nominations deadline: June 30, 1980.

Breast-Feeding the Newborn

CONTINUED FROM PAGES 373-378

TO OBTAIN ONE HOUR OF CATEGORY 1 AMA CME CREDIT, answer the following questions by circling the correct answer on the answer sheet below. Complete and clip the application form and mail it to: **Indiana University School of Medicine, Division of Continuing Medical Education, 1100 W. Michigan St., Indianapolis 46223.**

- The following is the recommended feeding for the normal full term infant:
 - Standard formula
 - Human breast milk
 - Goat's milk
 - Whole cow's milk
- The following are considered usual contraindications to breast feeding the newborn, with the exception of:
 - Mother does not desire to breast feed
 - Mother > 35 years of age
 - Severe congenital malformations
 - Maternal active tuberculosis
- Drugs excreted in breast milk include:
 - Aspirin
 - Darvon
 - Codeine
 - All of the above
- Drugs which are considered contraindications to breast feeding include all but which of the following:
 - Antithyroid medications
 - Lithium
 - Tylenol
 - Radioactive labels
- Fore milk is characterized by each of the following except:
 - Low fat content
 - Produced within the first 2-3 minutes of nursing
 - Produced at a constant rate in breast by "dialysis"
 - High caloric value
- Hind milk is characterized by each of the following except:
 - High fat content
 - Comprises 2/3 of milk supply
 - Low caloric value
 - Produced after 2-3 minutes of nursing
- Colostrum is felt to be particularly beneficial to the newborn because of:
 - Concentrated isoimmune factors (immunoglobulins, cells)
 - Low sugar content
 - Large volume produced
 - It is nutritionally satisfying
- Breast engorgement in a breast feeding mother should be treated by all of the following except:
 - Milk expression (manual or nursing)
 - Reducing the frequency of feeding
 - Breast massage
 - Warm compresses prior to nursing
- Mastitis is usually associated with each of the following except:
 - Pseudomonas
 - Staphylococcus aureus
 - Cracked nipples
 - Engorgement
- Suppression of lactation is achieved in most women successfully by the use of each of the following except:
 - Avoidance of suckling stimulus
 - Well supporting brassiere
 - Mild analgesics
 - Specific anti-lactation medications

Answers to the CME quiz that appeared in the May 1980 issue of THE JOURNAL. "Treatment of Anxiety States: Some Theoretical and Practical Aspects," by Jerry J. Dennis, M.D.

- | | |
|------|-------|
| 1. c | 6. a |
| 2. b | 7. d |
| 3. b | 8. c |
| 4. b | 9. c |
| 5. b | 10. a |

Answer sheet for Quiz: (Breast-Feeding)

- | | |
|------------|-------------|
| 1. a b c d | 6. a b c d |
| 2. a b c d | 7. a b c d |
| 3. a b c d | 8. a b c d |
| 4. a b c d | 9. a b c d |
| 5. a b c d | 10. a b c d |

I wish to apply for one hour of category 1 AMA Continuing Medical Education credit through the I.U. School of Medicine. I have read the article and answered the quiz on the answer sheet above. I understand that my answer sheet will be graded confidentially, at no cost to me, and that notification of my successful completion of the quiz (80% of the questions answered correctly) will be directed to me for my application for the Physician's Recognition Award of the American Medical Association. I also understand that if I do not answer 80% of the questions correctly, I will not be advised of my score but the answers will be published in the next issue of THE JOURNAL for my information.

Name (please print or type)

Address

Identification number (found above your name on mailing label)

Signature

To be eligible for credit for this month's quiz, send your completed, signed application before July 10, 1980, to the address appearing at the top of this page.

CANCER CORNER

The recently issued Surgeon General's Report on the Health Consequences of Cigarette Smoking for Women concluded that 1) women who smoke are subjected to lung cancer and other diseases just as men are, 2) cigarette smoking is a major threat to the outcome of pregnancy and well being of a new baby, and 3) women start and stop smoking for precisely the same reasons as men do.

"This startling report points up all over again the need for closer regulation of the tobacco industry and the toning down of its commercial activities," declared Dr. S. B. Gusberg, ACS national president and professor of gynecology at Mount Sinai School of Medicine, New York City.

Dr. Gusberg said the tobacco industry escapes most of the controls applied to other industries, pointing out that tobacco products often are exempted from laws designed to protect the public health.

He said, "The U.S. Food and Drug Administration is expressly forbidden to examine the potential hazards of substances found in tobacco products. It should be granted the authority to do so." He urged the FTC to "bear down harder" on the tobacco companies to make them display tar, nicotine and carbon monoxide levels on all cigarette packages and in their advertising.

The American Cancer Society, which already has invested \$2.4 million in interferon research, has allocated an additional \$3.4 million for further study of the substance.

Dr. Gusberg reported that early research with interferon "has been promising enough to warrant expansion of the Society's clinical trials." He said, "More extensive work is necessary to determine whether interferon will ultimately prove useful in the treatment of cancer."

Interferon, one of the scarcest medical substances in the world, costs as much as \$30,000 per patient, sometimes more. "If there's the slightest possibility that it might prove helpful to future cancer patients," Dr. Gusberg said, "we feel that every effort must be made to check it out."

Controlled clinical testing with interferon supplied by the ACS currently is in progress at 10 American medical centers. For its initial \$2 million outlay, the Society obtained enough of the substance to treat about 150 patients. "Although preliminary results have been good," Dr. Gusberg declared, "it's still too early to draw conclusions. To determine interferon's effectiveness, we'll have to study these patients over a long period of time and add more patients to the testing group."

"We're still very early into this research and must await data concerning final tumor response and any possible long-term side effects. Precise knowledge of dosage, dosage timing, coordination with other types of treatment such as surgery, radiotherapy and chemotherapy, and possible immune effects must be obtained before we can know the place of the interferons in clinical cancer therapy."

There are at least three kinds of human interferon, Dr. Gusberg explained. These are leukocyte interferon, fibroblast interferon and immune or lymphoblastoid interferon. Only leukocyte interferon is being used in the American Cancer Society's clinical testing program. Scarcity of the material has resulted in slow progress for the current research.

Although the newly announced funds will be used primarily for purchase of additional material, it is expected that substantial amounts will go into related patient studies as well as into projects aimed at

purifying the material and increasing its production.

Four kinds of cancer are now being studied under the Society's auspices. They are melanoma, multiple myeloma, cancer of the breast and lymphomas other than Hodgkin's Disease. Dr. Gusberg said supplementary funding probably will make it possible to add other types of cancer to the clinical trials list.

Interferon is a protein occurring naturally in the blood. It was discovered in 1957 by Alick Isaacs of Great Britain and Jean Lindemann of Switzerland. Early researchers noted that the substance appeared to fight virus infection and interfere with cell division. However, very little was done with interferon until small working quantities could be made available. The American Cancer Society announced its first financial commitment in August 1978.

Physicians' Reaction to Anti-smoking Material. A recent national study indicates that physicians are effectively using the Physician's Help Quit Kit and the Quitter's Guide in encouraging their patients to stop the smoking habit. Among the key conclusions:

- Receiving anti-smoking materials increased the extent to which physicians felt it was important for smoking patients to quit and prompted physicians to talk more to smoking patients about quitting.

- Receiving both sets of anti-smoking materials, i.e., both the Kit and the Guide, had a greater impact on physicians than receiving one or the other.

- Eighty-two per cent of physicians felt that the Kit should be distributed to other physicians and an even more impressive 94% felt that the Guide should be distributed to other physicians as handouts to their smoking patients.

WHEN ANXIETY AND TENSION MAGNIFY PAIN

IN MUSCULOSKELETAL DISEASE*



A non-narcotic one-two punch against pain, with concurrent relief of anxiety/tension

EQUAGESIC[®] IV

(meprobamate and ethoheptazine citrate with aspirin) Wyeth

EQUAGESIC—Abbreviated Summary

***INDICATIONS:** Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective, for the treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease or tension headache.

Final classification of the less-than-effective indications requires further investigation.

The effectiveness of Equagesic in long-term use, i.e., more than four months, has not been assessed by systematic clinical studies. The physician should periodically reassess usefulness of the drug for the individual patient.

CONTRAINDICATIONS: Equagesic should not be given to individuals with a history of sensitivity or severe intolerance to aspirin, meprobamate, or ethoheptazine citrate.

WARNINGS: Careful supervision of dose and amounts prescribed for patients is advised, especially with those patients with known propensity for taking excessive quantities of drugs. Excessive and prolonged use in susceptible persons, e.g., alcoholics, former addicts, and other severe psychoneurotics, has been reported to result in dependence on or habituation to the drug. Where excessive dosage has continued for weeks or months, dosage should be reduced gradually rather than abruptly stopped, since withdrawal of a "crutch" may precipitate withdrawal reaction of greater proportions than that for which the drug was originally prescribed. Abrupt discontinuance of doses in excess of the recommended dose has resulted in some cases in the occurrence of epileptiform seizures.

Special care should be taken to warn patients taking meprobamate that tolerance to alcohol may be lowered with resultant slowing of reaction time and impairment of judgement and coordination.

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with the use of minor tranquilizers (meprobamate, chlorthalidone, and diazepam) during the first trimester of pregnancy has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at the time of institution of therapy should be considered. Patients should be advised that if they become pregnant during therapy or intend to become pregnant they should communicate with their physicians about the desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breast-feeding patients, the drug's higher concentrations in breast milk as compared to maternal plasma levels should be considered.

Preparations containing aspirin should be kept out of the reach of children. Equagesic is not recommended for patients 12 years of age and under.

PRECAUTIONS: Should drowsiness, ataxia, or visual disturbance occur, the dose should be reduced. If symptoms continue, patients should not operate a motor vehicle or any dangerous machinery.

Suicidal attempts with meprobamate have resulted in coma, shock, vasomotor and respiratory collapse, and anuria. Very few suicidal attempts were fatal, although some patients ingested very large amounts of the drug (20 to 40 gm). These doses are much greater than recommended. The drug should be given cautiously, and in small amounts, to patients who have suicidal tendencies. In cases where excessive doses have been taken, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels. Hyperventilation has been reported occasionally. Any drug remaining in the stomach should be removed and symptomatic treatment given. Should respiration become very shallow and slow, CNS stimulants, e.g., caffeine, Meclazol, or amphetamine, may be cautiously administered. If severe hypotension develops, pressor amines should be used parenterally to restore blood pressure to normal levels.

ADVERSE REACTIONS: A small percentage of patients may experience nausea with or without vomiting and epigastric distress. Dizziness occurs rarely when meprobamate and ethoheptazine citrate with aspirin is administered in recommended dosage. The meprobamate may cause drowsiness but, as a rule, this disappears as therapy is continued. Should drowsiness persist and be associated with ataxia, this symptom can usually be controlled by decreasing the dose, but occasionally it may be desirable to administer central stimulants such as amphetamine or mephentermine sulfate concomitantly to control drowsiness.

A clearly related side effect to the administration of meprobamate is the rare occurrence of allergic or idiosyncratic reactions. This response develops, as a rule, in patients who have had only 1-4 doses of meprobamate and have not had a previous contact with the drug. Previous history of allergy may or may not be related to the incidence of reactions.

Mild reactions are characterized by an itchy urticarial or erythematous, maculopapular rash which may be generalized or confined to the groin. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema, and fever have also been reported.

More severe cases, observed only very rarely, may also have other allergic responses, including fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case), and hyperthermia. Treatment should be symptomatic such as administration of epinephrine, antihistamine, and possibly hydrocortisone. Meprobamate should be stopped, and reinstitution of therapy should not be attempted.

Rare cases have been reported where patients receiving meprobamate suffered from aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia. In nearly every instance reported, other toxic agents known to have caused these conditions have been associated with meprobamate. A few cases of leukopenia during

continuous administration of meprobamate are reported, most of these returned to normal without discontinuation of the drug. Impairment of accommodation and visual acuity has been reported rarely.

OVERDOSE: Two instances of accidental or intentional significant overdosage with ethoheptazine citrate combined with aspirin have been reported. These were accompanied by symptoms of CNS depression, including drowsiness and light-headedness, with uneventful recovery. However, on the basis of pharmacological data, it may be anticipated that CNS stimulation could occur. Other anticipated symptoms would include nausea and vomiting. Appropriate therapy of signs and symptoms as they appear is the only recommendation possible at this time. Overdosage with ethoheptazine combined with aspirin would probably produce the usual symptoms and signs of salicylate intoxication. Observation and treatment should include induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions.

DESCRIPTION: Each Equagesic tablet contains 150 mg meprobamate, 75 mg ethoheptazine citrate and 250 mg aspirin.

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*This drug has been evaluated as possibly effective for this indication.

Wyeth Laboratories
Philadelphia, Pa 19101



FOR MODERATE PAIN

A therapeutic dose
of acetaminophen
in one tablet

A therapeutic dose
of two complementary
analgesics

The convenience and
economy of a
dosage schedule of
one tablet, every four
hours as needed



WHY NOT WYGESIC[®] C

(65 mg propoxyphene HCl and 650 mg acetaminophen) Wyeth

WYGESIC—Abbreviated Summary

INDICATION: For the relief of mild-to-moderate pain.
CONTRAINDICATION: Hypersensitivity to propoxyphene or to acetaminophen.

WARNINGS: CNS ADDITIVE EFFECTS AND OVERDOSAGE: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, or other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. Toxic effects and fatalities have occurred following overdoses of propoxyphene alone or in combination with other CNS depressants. Most of these patients had histories of emotional disturbances or suicidal ideation or attempts, as well as misuse of tranquilizers, alcohol, or other CNS-active drugs. Caution should be exercised in prescribing large amounts of propoxyphene for such patients (see Management of Overdosage).

DRUG DEPENDENCE: Propoxyphene can produce drug dependence characterized by psychic dependence and less frequently, physical dependence and tolerance. It will only partially suppress the withdrawal syndrome in individuals physically dependent on morphine or other narcotics. The abuse liability of propoxyphene is qualitatively similar to codeine's although quantitatively less, and propoxyphene should be prescribed with the same degree of caution appropriate to the use of codeine.

USAGE IN AMBULATORY PATIENTS: Propoxyphene may impair the mental and/or physical abilities required for potentially hazardous tasks, e.g. driving a car or operating machinery. Patients should be cautioned accordingly.
USAGE IN PREGNANCY: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. **INSTANCES OF WITHDRAWAL SYMPTOMS IN THE NEONATE HAVE BEEN REPORTED FOLLOWING USAGE DURING PREGNANCY.** Therefore, propoxyphene should not be used in pregnant women unless, in the

judgement of the physician, the potential benefits outweigh the possible hazards.

USAGE IN CHILDREN: Propoxyphene is not recommended for children because documented clinical experience has been insufficient to establish safety and a suitable dosage regimen in the pediatric group.

PRECAUTIONS: Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine. The CNS depressant effect of propoxyphene may be additive with other CNS depressants, including alcohol.

ADVERSE REACTIONS: The most frequent adverse reactions are dizziness, sedation, nausea, and vomiting. These seem more prominent in ambulatory than in nonambulatory patients, some of these reactions may be alleviated if the patient lies down.

Other adverse reactions include constipation, abdominal pain, skin rashes, light-headedness, headache, weakness, euphoria, dysphoria, and minor visual disturbances. The chronic ingestion of propoxyphene in doses over 800 mg per day has caused toxic psychoses and convulsions. Cases of liver dysfunction have been reported.

DRUG INTERACTIONS: Propoxyphene in combination with alcohol, tranquilizers, sedative-hypnotics, and other CNS depressants has an additive depressant effect. Patients taking this drug should be advised of the additive effect and warned not to exceed the dosage recommended. (see Warnings) Confusion, anxiety, and tremors have been reported in a few patients receiving propoxyphene concomitantly with orphenadrine.

MANAGEMENT OF OVERDOSAGE: SYMPTOMS The manifestations of serious overdosage with propoxyphene are similar to those of narcotic overdosage and include respiratory depression (a decrease in respiratory rate and/or tidal volume, Cheyne-Stokes respiration, cyanosis), extreme somnolence progressing to stupor or coma, pupillary constriction, and circulatory collapse. In addition to these characteristics, which are reversed by narcotic antago-

nists such as naloxone, there may be other effects. Overdoses of propoxyphene can cause delay of cardiac conduction as well as focal or generalized convulsions, a prominent feature in most cases of severe poisoning. Cardiac arrhythmias and pulmonary edema have occasionally been reported, and apnea, cardiac arrest, and death have occurred.

Symptoms of massive overdosage with acetaminophen may include nausea, vomiting, anorexia, and abdominal pain, beginning shortly after ingestion and lasting for 12 to 24 hours. However, early recognition may be difficult since early symptoms may be mild and nonspecific. Evidence of liver damage is usually delayed. After the initial symptoms, the patient may feel less ill, however, laboratory determinations are likely to show a rapid rise in liver enzymes and bilirubin. In case of serious hepatotoxicity, jaundice, coagulation defects, hypoglycemia, encephalopathy, coma, and death may follow. Renal failure due to tubular necrosis, and myocardialopathy, have also been reported.

Ingestion of 10 grams or more of acetaminophen may produce hepatotoxicity. A 13-gram dose has reportedly been fatal.

TREATMENT: Primary attention should be given to the reestablishment of adequate respiratory exchange through provision of a patent airway and institution of assisted or controlled ventilation. The narcotic antagonists, naloxone, nalorphine, and levallorphan, are specific antidotes against the respiratory depression produced by propoxyphene. An appropriate dose of one of these antagonists should be administered, preferably IV, simultaneously with efforts at respiratory resuscitation and the antagonist should be repeated as necessary until the patient's condition remains satisfactory. In addition to a narcotic antagonist, the patient may require careful titration with an anticonvulsant to control seizures. Analgesic drugs (e.g. caffeine or amphetamine) should not be used because of their tendency to precipitate convulsions.

Oxygen, IV fluids, vasopressors and other supportive measures should be used as indicated. Gastric lavage may be helpful. Activated charcoal can absorb a significant amount of ingested propoxyphene. Dialysis is of little value in poisoning by propoxyphene alone. Acetaminophen is rapidly absorbed, and efforts to remove the drug from the body should not be delayed. Copious gastric lavage and/or induction of emesis may be indicated. Activated charcoal is probably ineffective unless administered almost immediately after acetaminophen ingestion. Neither forced diuresis nor hemodialysis appears to be effective in removing acetaminophen. Since acetaminophen in overdose may have an antidiuretic effect and may produce renal damage, administration of fluids should be carefully monitored to avoid overload. It has been reported that mercaptamine (cysteine) or other thiol compounds may protect against liver damage if given soon after overdosage (8-10 hours). N-acetylcysteine is under investigation as a less toxic alternative to mercaptamine, which may cause anorexia, nausea, vomiting, and drowsiness. Appropriate literature should be consulted for further information. (JAMA 237:2406-2407, 1977).

Clinical and laboratory evidence of hepatotoxicity may be delayed up to one week. Acetaminophen plasma levels and half-life may be useful in assessing the likelihood of hepatotoxicity. Serial hepatic enzyme determinations are also recommended.

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Wyeth Laboratories
Philadelphia, Pa 19101



NEWS NOTES

VA Names Training Sites

The Veterans Administration has named five VA medical centers as training sites for its \$1 million-a-year research program into the causes of alcoholism and drug abuse.

This VA Substance Abuse Fellowship project will be conducted at medical centers located in Bronx, N.Y., Coatesville, Pa., Palo Alto and San Francisco, Calif., and West Haven, Conn.

Training will encompass the care of veterans suffering from both alcoholism and drug abuse. Psychiatric and mental health aspects of diagnosis and treatment will be an essential part of the program.

School Health Project

The Agency for Instructional Television (AIT) of Bloomington, Ind. is producing a 12-part video series for a consortium of 22 state and provincial agencies.

The series, called "On the Level," will focus on the emotional and social growth of high school students. It will be available beginning in September.

The Corporation for Public Broadcasting has announced that it will grant \$270,860 to help finance the project. "On the Level" is the first series to receive a grant from the CPB Children's Program Project.

'Resuscitation Fundamentals'

Hewlett-Packard has published a 24-page booklet entitled "Introduction to Resuscitation Fundamentals." It is divided into five parts that allow the reader to study only those sections necessary, depending upon his or her knowledge of physiology. The sections describe the mechanical activity of the heart, the electrical activity of muscle cells and of the heart muscle specifically, fibrillation, and resuscitation. Numerous charts and diagrams aid the text.

Inquiries should be addressed to Inquiries Manager, Hewlett-Packard Company, 1507 Page Mill Road, Palo Alto, Calif. 94304. The booklet is available free of charge.

Juvenile Diabetes Information

The dietitian's complex role in treating insulin-dependent juvenile diabetes is the topic of a new audio cassette and study guide presented by the American Dietetic Association. The authors are Dr. Frank K. Thorp, Associate Professor of Pediatrics, and Paula Peirce, Registered Dietitian at Pritzker School of Medicine.

Write to American Dietetic Association, 430 N. Michigan Ave., Chicago 60611.

Bi-Monthly Alcoholism Magazine Set to Debut in July

The first issue of *ALCOHOLISM—THE NATIONAL MAGAZINE* will appear in July as a large circulation, general interest publication. Endorsed by the National Council on Alcoholism, the bi-monthly magazine will incorporate the Council's *PUBLIC JOURNAL*. It is planned as a national forum for both professionals and others concerned with preventive treatment and recovery. It also will educate adults and children about the use and abuse of alcohol.

Controlling Malignant Hyperthermia

"Malignant Hyperthermia: Etiology, Diagnosis and Management" is the title of a new slide-tape program from Norwich-Eaton Pharmaceuticals about the rare anesthesia-induced highly fatal complication. The mortality rate at one time was 90%. With Norwich-Eaton's new Dantrium® Intravenous the crisis may be reversed in almost all cases. Teaching institutions, hospitals and interested physicians may obtain the MH slide show and collateral materials without charge by writing the company at Norwich, N.Y. 13815.

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Upjohn Scientists Investigate Development of Diabetes

Scientists of the Upjohn Company are studying differences in the growth of pancreatic cells taken from normal Chinese hamsters as compared with cells taken from spontaneously diabetic Chinese hamsters.

When grown in tissue culture, cells from pancreatic islets of normal hamsters migrate outward, while those from diabetic hamsters have little tendency to migrate. The researchers have found that the difference in cellular behavior depends on glucose metabolism and ATP formation.

Research continues to determine whether such cellular behavior may be incident to diabetes.

Arizona Court Lacks Jurisdiction Over Indiana Hospital

An Arizona trial court cannot exercise personal jurisdiction over a physician and hospitals in Indiana, the Arizona Supreme Court has ruled.

A patient had been committed to an Indiana mental hospital after being found incompetent to stand trial for a violent crime. Four years later he was released and he moved to Arizona, where he murdered a child.

The father sued the Indiana hospital and physician for damages for releasing the patient. The court found that where there was no evidence that the Indiana parties knew the patient was going to Arizona or had had any contact with him since his release, the Arizona court could not exercise personal jurisdiction. — *Chavez v. State of Indiana for Logansport State Hospital*, 596 P.2d 698 (Ariz. Sup. Ct., June 5, 1979)

Courtesy of THE CITATION, Feb. 1, 1980.

Enzyme Decreases Linked To Diabetic Complications

Subnormal levels of an enzyme normally found throughout the body are closely associated with the blood vessel changes that accompany diabetic complications such as kidney failure and blindness.

This is the conclusion of an Upjohn researcher, Albert Y. Chang, Ph.D. He has demonstrated that a depression of beta-D-galactosidase occurs in Chinese hamsters and rats with the onset of diabetes. Dr. Chang stresses that, since many enzyme systems are involved in diabetes, much more research is necessary.

Search Warrant Restrictions

The Senate Committee on the Judiciary recently heard testimony on legislation proposed for the purpose of limiting the use of search warrants in seeking evidence from individuals not involved in criminal activity.

Noting the impact that this ruling could have on the confidentiality of medical records, Nancy Roeske, M.D., of Indiana University said that "physicians obligate themselves to protect the confidence of their patients. Even with the assurances of confidentiality, some patients are reluctant to speak openly with their physicians. If the confidentiality of patient communications could no longer be protected, such reluctance could become widespread, hindering the physician's ability to provide needed medical care."

Fibroblast Interferon Being Tested

Searle Pharmaceutical is originating the first large-scale production of fibroblast interferon for use in research in cancer treatment. Tissue culture methods produce a molecule which corresponds exactly to that occurring in the human body. The efficacy of interferon as an anti-cancer agent will be researched by scientists at the M.D. Anderson Hospital and Tumor Institute.

Official Family Briefings

The AMA has invited state medical associations to host an Official Family Briefing at their 1980 annual or interim meetings. Last year 31 state associations hosted such briefings, which are intended to promote a private, informal exchange of information on significant health care issues between AMA officials and state association leaders.

The primary state association participants last year were officers, trustees, and AMA delegates and alternate delegates. The AMA encourages state association presidents to invite the broadest leadership possible to the 1980 briefings. For more information, contact Office of EVP, AMA Headquarters.

VA Benefits for Amputees

The VA is reminding veterans with multiple amputations that they may be eligible for increased, retroactive benefits if they develop a heart condition related to their wounds. A study conducted for the VA by the National Academy of Sciences has demonstrated a relationship between war-related amputations and subsequent deaths from cardiovascular diseases.

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Young man, does your mother know what you do for a living?

1980 Journalism Awards Deadline

County medical societies must receive Indiana news media entries by June 30 for them to be eligible for the 1980 ISMA Journalism Awards competition.

All entries must have been published or aired from Jan. 1, 1979 through May 31, 1980. Judging, to begin in August, will be based on health and medical accuracy, significance, quality, interest and impact on the general public.

Competition coordinator is Barbara Lauter, ISMA public relations director. Tel: 317-925-7545 or 1-800-382-1721.

Marion County BULLETIN Wins Journalism Award

For the second consecutive year, the Marion County Medical Society BULLETIN has been recognized by Sandoz Pharmaceuticals in its annual medical journalism competition. The BULLETIN, competing in the county and city medical publications category, received Honorable Mention for excellence in design and editorial content. The monthly magazine, with a circulation of 1,450, is produced by Harold W. Hefner, editor, and Jackie Freers Stahl, assistant editor.

Here and There . . .

. . . **Dr. Ross Egger** of Daleville has been appointed chief teller of the July 20-24 meeting of the AMA House of Delegates.

. . . **Dr. Steven J. Jay** of Indianapolis has been elected president of the Indiana Thoracic Society.

. . . **Dr. Louis F. Romain** of Fort Wayne has been named recipient of the 1980 Marathoner Award, presented by the National Jogging Association. Last year he jogged more than 2,600 miles.

. . . **Dr. Ralph C. Wilmore** of Indianapolis has been elected president of the American Lung Association of Indiana.

. . . **Dr. John C. Johnson** of Evansville, president-elect of the Indiana Chapter, American College of Emergency Physicians, has been appointed to the Emergency Medical Services Commission for Indiana.

. . . **Dr. William D. Province** of Franklin, active for 30 years in battling lung disease, has been selected for the American Lung Association's Hall of Fame. He also has been chosen for the ALA's Indiana Hall of Fame.

. . . **Dr. Robert G. Reed** of Indianapolis, **Dr. Milton E. Gibson** of South Bend and **Dr. Ralph D. Millsaps** of Evansville have been named Fellows of the American College of Cardiology.

. . . **Dr. William E. Schoolfield** of Orleans has been named the 1980 Dogwood Festival "Citizen of the Year."

ISMA Favors Heimlich Maneuver

The Indiana State Medical Association has notified the State Board of Health that it supports the Heimlich Maneuver as "an appropriate emergency procedure for the choking victim."

The State Board of Health is responsible for implementing a program to place posters in restaurants that describe emergency procedures for the choking victim.

Ophthalmologists to Meet

The American Academy of Ophthalmology has rescheduled its 1980 Annual Meeting for Nov. 2-7 at McCormick Place in Chicago. The change was necessitated by the increasing attendance, which includes not only ophthalmologists but also many other physicians and health professionals. The program is based on 20 half-day symposia and 300 instructional courses, as well as scientific exhibits and a film program. The election occurs during the meeting, and all potential attendees will be provided information concerning absentee ballots. Televised election results will be a part of the traditional "President's Reception" on Tuesday night.



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AUXILIARY REPORT

Dorothy (Mrs. Herbert A.) Schiller
President, ISMA Auxiliary

Dear Doctor:

This month, the Auxiliary page is being written for your spouse. Please take THE JOURNAL home with you.

Greetings from The Indiana State Medical Auxiliary!

The highlight of our April House of Delegates in Evansville was the visit from AMA-A President Ruth Johnson and the reports of the county presidents. It was gratifying to learn of the various projects and programs in which county auxiliaries participated.

In my inaugural address, I called upon the delegation to accept my theme as our guiding principles for the year:

BE ACTIVE
BE INVOLVED
BE CONCERNED

The plea is to **BE ACTIVE** in Auxiliary, **BE INVOLVED** in the community, and **BE CON-**

CERNED about the future of medicine.

It is the counties that give the impetus and power to auxiliary life. Each has its individuality, its special place in the overall picture. Each has something to offer, a local need that must be recognized and met. You, as leaders, must go to your counties and make your auxiliaries understand the rare worth of their continued efforts and achievements in health education and services in your communities.

In addition, great effort should be made to increase auxiliary membership and recruit the spouses of medical students and residents. These young people are the future of medicine. They are our lifeblood and we must keep that lifeblood flowing!

Our main areas of concern and responsibility for the coming year will be health education, health services, and public relations with special emphasis on AMA-ERF, membership, legislation, "Shape

Up For Life," and cost containment.

In presenting our continuing programs and projects, I extend our sincerest appreciation and highest tribute to our county auxiliaries. It is only through you, through your efforts, your talents, your abilities, and your hard work that our hopes and dreams are being achieved. Energy is the key word today. But despite the fact that there is a lack of all kinds of power, resulting in an energy crisis, we most certainly know that amongst you there is no lack of will-power to create the human energy necessary for the accomplishment of our top priority programs in the coming year.

Auxiliaries, we need you! Please respond to the needs of your auxiliary. I very humbly ask you to respond with vigor and determination promoting our theme for 1980-1981.

BE ACTIVE!
BE INVOLVED!
BE CONCERNED!



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This product is prepared from human venous plasma. Each individual unit of plasma has been found nonreactive for hepatitis B surface antigen using the radioimmunoassay method of counter-electrophoresis.

INDICATIONS

Treatment of rabies, once clinical disease becomes apparent, is rarely if ever successful. Rabies vaccine (duck-embryo origin, Lilly Laboratories) with or without Rabies Immune Globulin (Human)—Hyperab[®] should, therefore, be given to all persons suspected of exposure to rabies, particularly to severe exposure. Whenever possible, Hyperab[®] globulin should be injected as promptly as possible after exposure. If initiation of treatment is delayed for any reason, however, Rabies Immune Globulin (Human) should be given just the same regardless of the interval between exposure and treatment.

Rabies virus is usually transmitted by the bite of a rabid animal, but can occasionally penetrate abraded skin with the saliva of infected animals. Progress of the virus after exposure is believed to follow a neural pathway, and the time between exposure and clinical rabies is a function of the proximity of the bite (or abrasion) to the central nervous system and the dose of virus injected. The incubation is usually 2 to 6 weeks, but can be longer. After severe bites about the head and neck, it may be as short as 10 days.

After initiation of the vaccine series, it takes 2 weeks or longer for development of immunity to rabies. Since most vaccine failures have occurred in cases of severe exposure, the value of immediate immunization with preformed rabies antibody cannot be over-emphasized.

Recommendations for use of passive and/or active immunization after exposure to an animal suspected of having rabies were detailed by WHO, and by the US Public Health Service Advisory Committee on Immunization Practices (ACIP).

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Rabies Immune Globulin (Human)—Hyperab[®] is contraindicated in repeated doses, once vaccine treatment has been initiated. Repeating the dose may bring about interference with full expression of active immunity expected from the vaccine. Hyperab[®] globulin is also contraindicated in individuals who are known to have an allergic response to gamma globulin or thimerosal.

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Slight soreness at the site of injection, and slight temperature elevation, may be noted at times. Sensitization to repeated injections of human globulin is extremely rare.

In the course of routine injections of a large number of persons with human gamma globulin, there have been a few isolated occurrences of angioneurotic edema, nephrotic syndrome, and anaphylactic shock after injection. Because of their rarity, it is difficult to determine whether such reactions are incidental, or causally related to the gamma globulin.

No instances of transmission of hepatitis B (homologous serum jaundice) have been reported from the use of human gamma globulin prepared by the fractionation methods employed by Cutter Laboratories, Inc.

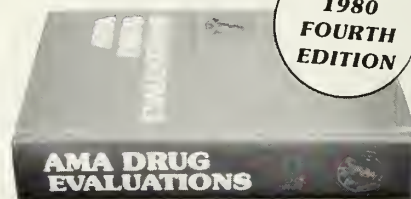
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FUTURE FILE

1980 Illinois Congress on CME

"Does CME Improve Physician Performance?" is the theme of the 1980 Illinois Congress on Continuing Medical Education, to be held Sept. 5-6 at the Oak Brook Hyatt House. Write Illinois Council on CME, 55 E. Monroe, Suite 350, Chicago 60603.

Antibiotic Review Conference

"Practical Strategies for Antibiotic Review-1980" is the title of the Second National Conference for Antibiotic Review, to be held at the Continental Plaza Hotel in Chicago Aug. 28-29. Write Muriel Myers, Suite 114A, 67 Peachtree Park Drive, Atlanta, Ga. 30309.

'Exam Cram' Slated

The Indiana Academy of Family Physicians will conduct an "Exam Cram" on patient management problems June 27-29 at the Airport Holiday Inn, Indianapolis.

The course is designed to prepare family physicians and family practice residents for the American Board of Family Practice two-day recertification examination in July.

The fee for AAFP members is \$225, which includes syllabus, luncheons, coffee breaks, and a copy of Family Practice Assessment Program Pre-Test. For AAFP-member F.P. residents, the fee is \$65. For non-member residents, the fee is \$75 and, for non-member physicians, \$325.

Contact Jackie Schilling, IAFP, 4847 S. High School Road, Indianapolis 46241. Tel: (317) 856-3757.

Pediatric Dermatology Seminar

The 8th Annual Pediatric Dermatology Seminar will convene at the Eden Roc Hotel, Miami Beach, Fla., Feb. 26-March 1, 1981. It will be followed by a 12-day post-seminar tour to Tahiti and New Zealand, with an optional extension to Australia. Write Guinter Kahn, M.D., 16800 N.W. 2nd Ave., Miami, Fla. 33169.

ACCP Annual Meeting

The 46th Annual Scientific Assembly of the American College of Chest Physicians will convene at the Sheraton Boston Hotel Oct. 26-30. More than 30 Category 1 credit hours may be obtained during the program. Contact Dale E. Braddy, Director of Education, American College of Chest Physicians, 911 Busse Highway, Park Ridge, Ill. 60068.

Duke Postgrad Course

A six-day postgraduate course will be presented by the faculty of the Department of Radiology, Duke University Medical Center July 28-Aug. 2 at Atlantic Beach, N.C.

Scientific sessions will cover pediatric and adult diagnostic radiology, including nuclear medicine, CT and ultrasound. The course is approved for 30 Category 1 credit hours toward the AMA's Physician Recognition Award. The registration fee is \$250, or \$125 for those in training if accompanied by a letter from the appropriate department chairman.

For details, contact Robert McLelland, M.D., Program Director, Radiology-Box 3808, Duke University Medical Center, Durham, N.C. 27710. Tel: (919) 684-4397 or 2711.

Gynecologic Cancer

Gynecologic cancer will be the subject of a national conference to be conducted by the American Cancer Society at the Los Angeles Hilton, Oct. 9-11. No registration fee is required, but advance registration is requested.

The session is approved for 16 hours of AMA Category 1 credit and for 16 AAFP prescribed hours.

Write to Nicholas G. Bottiglieri, M.D., 777 Third Ave., New York City 10017.

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OBITUARIES

Bennett B. Harvey, M.D.

Dr. Harvey, 67, a former Lafayette pathologist, died April 4 in Jacksonville, Fla., where he had lived two years.

He was a 1939 graduate of the Indiana University School of Medicine, and was a veteran of both World War II and the Korean War.

Dr. Harvey was a member of the American Society of Clinical Pathologists.

Howard C. Slaughter, M.D.

Dr. Slaughter, 66, an Evansville ophthalmologist, died April 16 of injuries sustained when the vehicle he was driving struck a tree. According to the Spencer County coroner, he was being treated for arterial sclerosis.

He was a 1940 graduate of the University of Nebraska Medical School.

Dr. Slaughter was a Fellow of the American College of Surgeons, a member of the American Academy of Ophthalmology and Otolaryngology, and a Diplomate of the American Board of Ophthalmology.

Memorials

Indiana Medical Foundation

The Indiana Medical Foundation, Inc. was formed by the Indiana State Medical Association "for religious, charitable, scientific, literary or educational purposes." It provides financial assistance to support the educational mission of THE JOURNAL.

Contributions made to the Foundation are deductible by donors in accordance with the Internal Revenue Code. Gifts are deductible for Federal estate and gift tax purposes.

The Foundation is pleased to acknowledge the receipt of gifts in remembrance of the following individuals:

Raymond Calvert, M.D.
Herman Baker, M.D.
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John Sullivan
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Jack E. Pilcher, M.D.
Joseph Finneran, M.D.

Joseph C. Finneran, M.D.

Dr. Finneran, 56, chief of surgery at St. Vincent Hospital in Indianapolis since 1957, died April 4 at the hospital.

A native of North Andover, Mass., he received his M.D. degree in 1947 from Johns Hopkins University.

Dr. Finneran was a clinical professor of surgery at the Indiana University School of Medicine and also served on the school's admissions committee. He was a former secretary and president of the Indiana chapter of the American College of Surgeons, and was ACS governor from 1975 to 1979. He also was a former vice-president and board member of the Marion County Medical Society.

V. Brown Scott, M.D.

Dr. Scott, 73, a retired Shelbyville physician, died April 14 in William S. Major Hospital, Shelbyville.

He received his M.D. degree from the University of Chicago in 1935. He practiced internal medicine 30 years at the Inlow Clinic, retiring in 1973.

Dr. Scott, who held a Ph.D. in physiology and taught five years at the I.U. School of Medicine, was a senior member of the ISMA. He also was a member of the American Geriatrics Society.

Robert H. Terry, M.D.

Dr. Terry, 63, died April 4 at his home in Booneville.

He received his M.D. degree in 1957 from the University of Tennessee. He had practiced in Booneville since 1958.

Dr. Terry, a former secretary and later vice-president of the Warrick County Medical Society, was a member of the American Academy of Family Physicians.

Marlow W. Manion, M.D.

Dr. Manion, 78, a retired Indianapolis otolaryngologist, died May 8 in a local nursing home.

He was a 1926 graduate of Indiana University School of Medicine. He retired in 1972.

Besides his private practice, Dr. Manion was a professor and chairman of the Department of Otolaryngology and Bronchoesophagology at the I.U. School of Medicine. A senior member of the ISMA, he was a member of the American Academy of Ophthalmology and Otolaryngology and the American Laryngological, Rhinological and Otolological Society.

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10.	Lee H. Trachtenberg, Munster	Borron M. F. Palmer, Hammond	May 31, 1980, Crown Point
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FAMILY PRACTITIONER-TAMPA BAY AREA-FLORIDA—Federally qualified HMO is recruiting family practitioners for ambulatory care facilities in Clearwater, Florida. Competitive salary and comprehensive benefit program with opportunity to participate in academic program available. If team interaction and casual living appeal to you, send CV to: Prepaid Health Care, Inc., Attn: Jerry Williamson, M.D., 1417 S. Belcher Road, Clearwater, Florida 33516. Tel: (813) 535-3474.

MADISON, INDIANA—Large, established practice available in near future in beautiful, thriving southern Indiana community. I am retiring, having been in the same location for 40 years. Large office space available. Office equipment and furnishings valued at \$20,000. Will sacrifice at reasonable fee. Wm. A. Shuck, M.D., 414 N. Mulberry St., Madison, Ind. 47250. Tel: (812) 265-3854.

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WHAT'S NEW?

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ANCHOR PRESS of the Doubleday Company has released *Behind Closed Doors: Violence in the American Family*. It is written by Murray Strauss and Richard J. Gelles, both associate professors of sociology, and Suzanne Steinmetz, an associate professor at the College of Home Economics. Eight years of interviews revealed that domestic violence involves children and adults; it cuts across all blood ties, education levels and incomes, and persists in families from generation to generation. The book is illustrated and contains an index and bibliography. 312 pages, \$10.95.

THE PRACTISING LAW INSTITUTE has just released two books: *Practice Manual for Social Security Claims and Hospital Liability: Law and Tactics (Fourth Edition)*. The first book guides the practitioner through the legal and practical problems that face a claimant of Social Security benefits, especially disability benefits. The process of application, reconsideration before a judge and appeals within the SSA and judicial review are covered. There is also a comprehensive set of appendixes. The 440-page book sells for \$35. The second named book is written for attorneys and hospital administrators, runs 790 pages and sells for \$45.

THE DIAGNOSTIC CAPABILITIES and cost effectiveness of the CT scanner are discussed in *Findings in CT: A Clinical and Economic Analysis of Computed Tomography*. The author of the 235-page book, Harry Wiener, M.D., is director of professional information for Pfizer Pharmaceuticals and Diagnostic Products. Included is a bibliography of more than 300 references.

IT SEEMS EVERYONE is working on or talking about interferon. Human Sciences Press has released a book entitled *Interferon and Nonspecific Resistance*. The author is Dr. Alexander Yabrov, the Russian physician who developed a method of producing interferon from white blood cells infected with virus. The text discusses the activities of interferon, methods of producing it and its role in cell-mediated immunity, particularly in anti-cancer and in transplant immunity. It is priced at \$39.95.

DELL PUBLISHING announces two books for nutrition minded shoppers—*The Dell Color-Coded Low Salt Living Guide* and *The Dell Color-Coded Low Fat Living Guide*. Each is authored by Janet James and Lois Goulder. Along with the color-coded supermarket section, the guides also include sections on low-fat/low salt cooking; dining out guides with breakfast, lunch and dinner menus for a variety of foods that contain low-salt/low fat; and health guides with commonly asked questions on diet, high blood pressure and heart disease answered by Abby G. Abelson, M.D., an expert in this section of the nutrition field. Each book is priced at \$2.50.

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